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Self-directed personal assistance
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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: INTRODUCTION SUBJECT: Manual Program

OBJECTIVE: This manual provides policies, procedures, data, information, and instructions covering the Self-Directed Personal Assistance Services Program. This manual replaces all previously issued policy and procedural information relating to the Self-Directed Personal Assistance Services Program.

MANUAL REVISIONS: Changes to program policy are transmitted by manual page revisions. Manual revisions are completed by the manual originator two times yearly. Critical information will be transmitted immediately.

Manual pages contain valuable information for long-term retention and are formally prepared, edited, identified, filed, and indexed. Upon receipt, remove the obsolete manual pages and replace with the new and revised pages.

CONTROL NUMBER--The control number for each manual page is the SDPAS number. For accurate placement, file all documents in numerical sequence (from FRONT to REAR) in the appropriate manual chapter.

MANUAL MAINTENANCE: MANUAL HOLDER'S RESPONSIBILITY--The manual holder is responsible for inserting documents and keeping the manual up-to-date. The Contents Index indicates the publication date of each subject listed to assist in auditing the manual contents.

Missing or Superseded Documents--Send requests to:

Community Services Bureau
Senior & Long Term Care Division
PO Box 4210
Helena, MT 59604

INFORMATION RETRIEVAL:

CONTENTS INDEX--This index lists the subjects by number.

Contents Check--To determine whether a particular document is the latest one published, check the date of page 1 of the document against the publication date listed in the Contents Index. At least once a year, check all documents to be certain that the manual is complete and up-to-date.

ALPHA SUBJECT INDEX--This index lists the subjects alphabetically.

REVISION PERIODS--Indexes are updated to cover all changes, to include all new documents being added, and to remove obsolete data, documents, or forms.

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Department of Public Health and Human Services	SECTION: INTRODUCTION
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Clarifying/Interpreting Policy or Procedure

If, after consulting this manual, individuals are unable to answer questions or resolve issues that arise in the course of their work, a clarification or interpretation of policy may be requested from the Regional Program Officer (RPO). (Refer to section SDPAS 803 for a list of RPOs.)

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ACTIVITIES OF DAILY LIVING--For the purpose of this program are limited to bathing, dressing, grooming, toileting, transferring, positioning, mobility, meal preparation, eating, exercise, and medication assistance.

ANNUAL REVIEW—A consumer review conducted by a licensed nurse from the Mountain Pacific Quality Health Foundation once every 365 days.

CASE MANAGEMENT--A team made up of a nurse and a social worker who are responsible for managing services provided to eligible consumers under the Home and Community Based Services (HCBS Waiver) Program.

CMS--Centers for Medicare/Medicaid Services is a Federal agency responsible for the oversight of Medicare and Medicaid services

CONSUMER--A person who is eligible for Medicaid and receives personal assistance from the Department through a provider agency.

DEPARTMENT--The Montana Department of Public Health and Human Services.

ELIGIBILITY STAFF--An employee in a County Office of Human Services who is responsible for determining financial eligibility for Medicaid.

FISCAL INTERMEDIARY--An agency which contracts with the Department to process all Medicaid claims for services. In Montana, this is ACS-Affiliated Computer Services.

FOUNDATION—Mountain Pacific Quality Health Foundation is a quality improvement organization that contracts with the Department to perform the authorization functions of the Personal Assistance Services Program.

HEALTH CARE PROFESSIONAL (HCP)--A health care professional is a physician assistant (certified), nurse practitioner, registered nurse, occupational therapist or a medical social worker working as a member of a case management team for the purposes of the Home and Community Based Services program. This does not include an RN who is employed by the provider agency.

HEALTH MAINTENANCE ACTIVITIES-- Are skilled tasks that are exempt from the Nurse Practice Act. They are associated with bowel programs, wound care, urinary system management, and administration of medications if the activities, in the opinion of the physician or other health care professional for the person with a disability, could be performed by the person if the person were physically capable and if the procedure may be safely performed in the home.

HOME AND COMMUNITY BASED SERVICES (WAIVER) PROGRAM (HCBS)--The home and community based services is referred to as the Medicaid waiver program because the Federal government waived certain Medicaid statutory requirements to allow the State to provide a board array of home and community based services as an alternative to institutional care. The State can determine the HCBS provided under the waiver but they must be approved by CMS as cost effective and necessary to prevent institutionalization.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)--activities that reflect independence in daily self-care, but are not critical to living alone. For the purpose of this program they are limited to housecleaning, shopping and laundry.

MEDICICALLY NECESSARY SERVICE means a service or item reimbursable under the Montana Medicaid program, which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: endanger life; cause suffering or pain; result in illness or infirmity; threaten to cause or aggravate a handicap; or cause physical deformity or malfunction.
37.82.102(18)

PERSONAL REPRESENTATIVE -- An unpaid individual who is directly involved in the day to day care of the consumer, and is available to direct care in the home on a consistent

basis. This individual would assume the role of the consumer for the purpose of managing personal assistants.

PERSONAL ASSISTANCE--Medically necessary in-home services provided to consumers whose chronic health problems cause them to be functionally limited in performing activities of daily living.

PERSONAL ASSISTANT--An employee of the provider agency who helps the consumer with activities of daily living.

PHYSICIAN/HEALTH CARE PROFESSIONAL APPROVAL --The consumer□s physician or health care professional approves services by signing the Personal Assistance Services Plan/Physician Order.

PRIOR AUTHORIZATION--A screening completed by the Foundation establishing the need for and limit of services for a consumer.

PROGRAM MANAGER--The Department employee responsible for overall management of the Personal Assistance Services Program.

PROVIDER AGENCY--An approved agency which enrolls with the Department to provide oversight of self-directed personal assistance services.

TRAVEL TIME--Time spent in travel by a personal assistant as part of his principal activity, such as travel time between consumer home visits. Travel time does not include time from the personal assistant's home to the first consumer or from the last consumer home visit to the personal assistant's home.

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SKILLED SERVICES: Services which are outside the definition of health maintenance tasks may not be performed under this program (see SDPAS 102).

EXCLUDED SERVICES: Personal assistance services do not include services which maintain an entire household or family or which are not medically necessary. These include, but are not limited to the following:

1. Cleaning floor and furniture in areas consumers do not use or occupy. For example, cleaning entire living areas if the consumer occupies only one room.

2. Laundering clothing or bedding the consumer does not use. For example, laundering for the entire household rather than laundering just the consumer's clothes.

3. Shopping for groceries or household items consumers do not need for health care and nutritional needs. Attendants may shop for items consumers need but that are used by the rest of the household.

4. Supervision (except as allowed under the Home and Community Based Services Program), respite care, babysitting, or friendly visiting.

5. Maintenance of pets except in the case where the animal is a certified service animal.

   a. An attendant may assist with offering food and water, letting the animal out to exercise, and brushing/combing the animal's coat; and

b. Provide non-routine bathing in circumstances where the animal needs immediate attention.

c. These services must be absorbed in the recipient's current plan of care. No additional hours will be authorized.

6. Home and outside maintenance. For example, lawn care, window washing, and wood cutting. Snow removal is permitted only to clear a path for accessibility to vehicle or curb.

PERSONAL ASSISTANCE SERVICES TO CHILDREN: Federal Medicaid law defines a child as an individual under the age of 21. Personal Assistance Services are not available to relieve a parent of their child caring or other legal responsibilities. Personal assistance for disabled children may be appropriate when the child is at risk of institutionalization unless the services are provided. In authorizing services to disabled children, the age-appropriateness of parental assistance should be considered. (Refer to SDPAS 318.)

CONSUMER CAPABILITIES: The consumer must be capable of making choices about activities of daily living, understand the impact of these choices and assume responsibility for the choices, or have a personal representative residing within or outside the household willing to assist the consumer in making choices and to direct the care in the home on a consistent basis. The guidelines for personal representative can be found at SDPAS 313.

The consumer must be capable of managing all tasks related to service delivery. This includes recruitment, hiring, scheduling, training, directing, and dismissal of attendants. **Consumers who are incapable of managing these tasks should not be admitted to the program.** A personal representative may assume these responsibilities on behalf of the consumer. (Refer to SDPAS 313.)

The consumer or consumer's Personal Representative must understand that the provision of services is based upon mutual responsibility between them and the provider agency.

RESTRICTIONS: Consumers who participate in Self-Directed Personal Assistance Services are restricted from utilizing agency managed personal assistance services except when the consumer's emergency backup plan fails.

Consumers who are authorized to manage specific health maintenance tasks are restricted from utilizing skilled nursing home health services for the routine completion of such tasks.

Should the consumer's emergency back up plan fail, skilled nursing services of a home health agency may be utilized.

Tasks that are <u>not</u> authorized for management by the consumer, may be performed through skilled nursing services of a home health agency.

For a minor child (recipient under age 18) to participate in this program, a personal representative must be utilized. It is not appropriate to have one parent act as the personal representative and the other assume the role as the paid attendant.

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Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES

SECTION: ELIGIBILITY

SUBJECT: Dually Enrolled Providers

Providers of Self-Directed Personal Assistance Services who also are enrolled providers for regular (or agency based) Personal Assistance Services must maintain separateness.

Separate records of services must be maintained when a consumer exits one program and enters the other; the provider must close one chart and open another. Records for the two services should not be commingled.

Consumers can not participate in both programs at the same time.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: PROGRAM DESCRIPTION SUBJECT: Program Goals

The purpose of the Self-Directed Personal Assistance Services Program is to prevent or delay institutionalization by providing medically necessary, long-term maintenance or supportive care in the home.

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INTRODUCTION AND LEGAL BASE--Personal assistance is an optional Medicaid (Title XIX) program authorized by Section 1905(a)(18) of the Social Security Act and 42 CFR 440.170(f). The development of the Self-Directed Personal Assistance program is the result of the passage of House Bill 504 in the 1995 Legislative Session.

The purpose of the Self-Directed Personal Assistance Services Program is to allow the consumer to manage their personal assistant services and health maintenance tasks. The program has been designed to prevent or delay institutionalization by providing medically necessary, long-term maintenance or supportive care in the home.

Sections 37.40.1301 through 37.40.1315 of the Administrative Rules of Montana (ARM) provide the state legal authority to implement the Self-Directed Personal Assistance Services Program. (Refer to SDPAS 1004 for a copy of the Self-Directed Personal Assistance Services ARM.)

This manual contains descriptive material, program requirements and procedures for the Self-Directed Personal Assistance Services Program.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICE	**SECTION:** PROGRAM DESCRIPTION **SUBJECT:** Federal Requirements

Reference: 42 CFR 440.167

GENERAL PROGRAM DESCRIPTION:

FEDERAL REQUIREMENTS--The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services(CMS), sets forth guidelines for Medicaid programs to obtain federal financial participation (FFP).

SUMMARY--These sections of the CFR define personal assistance services, who can deliver services, and consumer eligibility.

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ORGANIZATIONAL RESPONSIBILITIES--The Personal Assistance Services Program has multiple levels of agency involvement. The responsibilities of the organizations follow.

FEDERAL: The U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), is the federal agency responsible for administering the Medicaid Program.

STATE: The Department of Public Health and Human Services (DPHHS) is the state agency responsible for administering the Medicaid Program.

DIVISION: The Senior and Long Term Care Division is responsible for developing, implementing, and monitoring policies and procedures for all senior and long term care services, including the Medicaid Personal Assistance Services Program. (Refer to PAS 801 for the Division Organizational Chart.)

REGIONAL PROGRAM OFFICERS: Regional Program Officers (RPOs) are Department employees supervised by the Community Services Bureau of the Division. They are located in DPHHS District Offices around the state. RPOs are primarily responsible for local representation of the Community Services Bureau programs, which include preadmission screening, personal assistance, self-directed personal assistance, home and community based services (HCBS), hospice, home dialysis, and home health services. (Refer to SDPAS 803 for a directory of Regional Program Officers.)

MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION: The Mountain Pacific Quality Health Foundation (Foundation) is a quality improvement organization (QIO) that contracts with the Department to perform prior authorization functions of the Personal Assistance Services Program.

ELIGIBILITY STAFF: Eligibility Staff are Department employees located in County Offices of Public Assistance who determine financial eligibility for Medicaid. (Refer to SDPAS 808 for a directory of County Offices of Public Assistance.)

FISCAL AGENT: The Department currently contracts with ACS, Inc. to process all Medicaid claims.

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MEDICAID OVERVIEW--The purpose of the Medicaid Program is to provide Medicaid eligible and medically needy persons with ongoing and preventive medical care necessary for maintaining their health and promoting their own self-care. The Medicaid Program was created in 1965 by Congress through Title XIX of the Social Security Act and was implemented in Montana in 1967 through Title 53, Chapter 6 of the Montana Codes Annotated and Section 46.12 of the Administrative Rules of Montana. The Montana Department of Public Health and Human Services is the designated single state agency for administering the Medicaid Program.

FEDERAL REQUIREMENTS--To receive federal funds for the program, the state must follow the federal regulations in 42 CFR, Parts 430 to 460. The regulations provide for two types of Medicaid Programs: mandatory and optional. Mandatory programs must be offered for states to receive federal Medicaid funds. Federal Medicaid funds are available for optional programs if state legislatures authorize the expenditure of state funds.

STATE PLAN--States define the extent and scope of services provided, service standards, and rates of payment to providers. The Department provides these details to HCFA in a State Plan which can be amended at any time. Services available to all Medicaid consumers are called State Plan services.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: PROGRAM DESCRIPTION SUBJECT: Medicaid Services

Reference: 42 CFR 440.210 and 440.220

MANDATORY SERVICES--Medicaid services required by the federal government include:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals under age 21. In addition to all available State Plan Medicaid services, children may also receive these services: chemical dependency treatment, chiropractic, dietitian, residential treatment facilities, private duty nursing, respiratory therapy, school-based services, therapeutic group and foster care.
- Family Planning
- Home Health (For individuals age 21 and over, supplies, nursing services, and aide services only.)
- Inpatient Hospital
- Laboratory and X-ray
- Medical and surgical services of a dentist
- Nurse Midwife
- Nurse Practitioner
- Nursing Facility Care
- Outpatient Hospital
- Physician
- Rural Health Clinics (including Federally Qualified Health Centers)

OPTIONAL SERVICES--Medicaid services that Montana has chosen to provide include:

- Ambulatory Surgical Centers
- Audiology/Hearing Aids
- Community Mental Health
- Dental and Denturist Services
- Diagnostic Clinics
- Durable Medical Equipment, Prosthetic Devices, Medical Supplies
- Eyeglasses and Optometric Services
- Freestanding Dialysis Clinics
- Home Dialysis Attendant Care
- Home Infusion Therapy
- Hospice
- Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Licensed Professional Counselors
- Mid-level Practitioners (Nurse Specialist, Physician Assistant, Advanced Practice Nurse, and Certified Nurse Midwife)
- Personal Assistance; Self-Directed Personal Assistance
- Podiatry
- Prescribed Drugs
- Psychology
- Speech, Occupational, and Physical Therapy
- Social Work

- Targeted Case Management
- Transportation Services

<u>PROGRAM LIMITATIONS</u>--States have the option to establish limitations on the amount of services available to Medicaid consumers.

Refer to PAS 1006 for a summary of Montana's Medicaid services. The summary outlines program scope, limitations, reimbursement, and copayment requirements for all covered services.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: PROGRAM DESCRIPTION SUBJECT:

Reserved

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DESCRIPTION OF MEDICARE--Medicare is a federal health insurance program for persons 65 years of age and older, and certain persons under the age of 65 who are disabled or who have End Stage Renal Disease. Unlike Medicaid, persons do not have to meet an income test to qualify for Medicare. Eligibility is based on the individual's work history under the Social Security or Railroad Retirement systems.

PROGRAM ADMINISTRATION--Medicare, like Medicaid, is a federal program administered by the Health Care Financing Administration (HCFA). Medicare is financed from Social Security taxes and monthly premiums and covers the same services and supplies nationwide.

HOSPITAL INSURANCE (PART A)--Medicare hospital insurance helps pay for medically necessary inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

MEDICAL INSURANCE (PART B)--Medicare medical insurance helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and a number of other medical services and supplies not covered by hospital insurance. Medical insurance can also help pay for necessary home health services when hospital insurance cannot pay and the consumer doesn't have Part A Medicare.

DEDUCTIBLES AND CO-INSURANCE--Medicare does not pay the full cost of some covered services. As with most private health insurance policies, Medicare has deductibles and co-insurance that must be paid by the insured person. If the Medicare insured person also receives Medicaid, Medicaid may pay some of the deductible and co-

insurance costs. Medicaid may also pay for the person's medical insurance premium.

PAYMENT SYSTEM--Medicare payments are handled by private insurance organizations under contract with the federal government. Organizations handling Part A claims are called intermediaries and organizations handling Part B claims are called carriers.

In Montana, the intermediary and carrier is either Blue Cross/Blue Shield or WellMark. Medicare's basis for how the payments will be made is called "assignment." "Assignment" means that the provider bills, receives and accepts the payment as payment in full. "Non-Assignment" means the provider does not accept the payment rate and the client is responsible for the total charges regardless of what Medicare allows. This principle does not apply in Medicaid since Medicaid payment is made only to providers and is payment in full.

FURTHER INFORMATION--For more detailed information about the Medicare Program, contact Blue Cross/Blue Shield.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: GENERAL PROGRAM ADMINISTRATION SUBJECT: Civil Rights

GENERAL RULE--Title VI and Title IX of the Civil Rights Act require that no person shall, on the grounds of race, color or national origin, creed, sex, religion, political ideas, marital status, age or handicap, be excluded from participating in, be denied benefits, or otherwise be subjected to discrimination under any program receiving federal funding.

Affirmative steps must be taken to employ and advance in employment qualified individuals with disabilities.

COMPLIANCE--All contracts with providers contain a section on civil rights. Providers shall comply with the Civil Rights Act and the Montana Human Rights Act, Title 49, Chapter 2, MCA, as amended and all requirements imposed by or pursuant to the regulation.

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Department of Public Health and Human Services	SECTION: GENERAL PROGRAM ADMINISTRATION
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Fair Hearings

Reference: ARM 37.5.304 - 37.5.337

REQUIREMENT--Any Medicaid provider or Medicaid consumer may appeal any adverse action which is felt to have affected the amount or scope of Medicaid payments received and/or eligibility for Medicaid.

ADVERSE ACTION--An adverse action means:

1. A failure of the Department to provide a claimant an opportunity to make application for benefits;

2. A failure of the Department to act promptly on a claimant's application for benefits;

3. An action by the Department denying, suspending, reducing or terminating benefits of a claimant;

4. An action by the Department establishing conditions on the manner or form of benefits, including restrictive or protective payments, or establishing conditions for the receipt of benefits, including a work requirement;

5. An action by the Department to deny, terminate or fail to renew certification or a provider agreement for the Medicaid program for any skilled nursing facility or intermediate care facility;

6. An action by the Department to deny, suspend, revoke or terminate or fail to renew certification, licensure or the registration certificate of the provider;

7. An action by the Department establishing the rate of reimbursement for a medical assistance provider or denying in whole or part a medical assistance provider's claim for services or items; or

8. Any other Department action or determination with respect to which a right to hearing is specifically granted by Department rule, but for which a hearing process is not otherwise provided.

<u>REQUESTING FAIR HEARINGS</u>--A provider, consumer, or his/her official representative must request a hearing in writing and mail the request to the Department of Public Health and Human Services, Hearings Officer, P.O. Box 202951, Helena, MT 59620-2951. A provider request must be postmarked or delivered to the Department no later than 30 calendar days following the date of notice of the determination. An applicant or consumer request must be postmarked or delivered no later than 90 calendar days following the date of notice of determination.

<u>CONDUCTING FAIR HEARINGS</u>--Fair Hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding and must conform to federal and state laws, regulation, or policy and must be based exclusively on evidence and other material introduced at the hearing. An administrative review of the action will precede a Fair Hearing. Either the Hearing Officer or the parties requesting the hearing may ask for a pre-hearing conference.

<u>ADMINISTRATIVE REVIEW</u>--The purpose of the administrative review is for the Department to reconsider its proposed action. The requestor of the hearing will review the matter with the Department representative, present additional information to the Department concerning the action, and obtain additional explanations from the Department on the reasons for the action. The Department will inform the individual of the determination after the administrative review has been completed.

PRE-HEARING CONFERENCE--The purposes of the pre-hearing conference are to consider simplification of the legal and factual issues in preparation for the hearing, obtain admissions of fact and documents, explore the possibility of settlement, establish what evidence and witnesses will be presented, and discuss any other matters that may aid in disposing of the Fair Hearing.

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Department of Public Health and Human Services	SECTION: GENERAL PROGRAM ADMINISTRATION
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Release of Information/ Confidentiality

REQUIREMENT--Federal law requires that Medicaid information about an applicant/ consumer and provider eligibility, or the amount of assistance and services provided is confidential. Under this protection, information regarding consumers cannot be released without their written consent. (Refer to SDPAS 1008 for an example of a consent form.)

Information released for purposes directly connected with administration of the Medicaid Program does not require consumer consent such as:

1. Establishing eligibility;

2. Determining the amount of medical assistance;

3. Providing services for consumers; and

4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid fraud or abuse.

PROCEDURES--The personal assistance agency should develop procedures to ensure that confidentiality is maintained. These procedures must include at least the following:

1. A determination that the individual requesting information will be using it for purposes directly connected with administration of the Medicaid Program.

2. Documentation of the date, purpose, and requesting individual/agency in the consumer record.

3. Denial of any request for consumer information unrelated to the administration of the Medicaid Program until a consumer signed and dated release of information is received.

All Department application forms state that the confidential information provided by the consumer will be protected and will only be used for purposes directly related to administration of the program.

FREEDOM OF INFORMATION--Consumers have a right to view their own records.

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Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES

SECTION: GENERAL PROGRAM ADMINISTRATION

SUBJECT: Third Party Liability (TPL)

Reference: ARM 37.85.407

REQUIREMENT--According to state and federal law, the state must take all reasonable measures to determine the legal liability of third parties to pay for health care and services covered by Medicaid.

The Medicaid Program is the payor of last resort to other insurance programs. Medicaid does pay before Crime Victim Compensation Funds, Indian Health Services, and Disaster Relief Funds.

If a third party source is known to the provider, the provider must bill the third party before billing Medicaid and indicate any amount received from the third party on the Medicaid claim. Providers must submit a copy of the statement of payment or denial from the resource when billing for any balance.

Examples of third party resources include:

- Medicare
- Veterans' Administration Medical Payment
- Private Insurance
- TRICARE and TRICARE for Life (formerly Civilian Health and Medical Program of the Uniformed Services-CHAMPUS)
- Workers' Compensation

THIRD PARTY LIABILITY QUESTIONS--Questions about third party policy or claims submission should be directed to the TPL Unit of the Quality Assurance Division or ACS's Provider Relations Section.

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Department of Public Health and Human Services	**SECTION:** GENERAL PROGRAM ADMINISTRATION
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SUBJECT:** Fraud and Abuse

Reference: ARM 37.85.501 - 37.85.513

REQUIREMENT--The Department is charged by federal and state law with the responsibility of identifying, investigating, and referring to law enforcement officials cases of suspected fraud or abuse of the Medicaid Program by either providers or consumers. Sanctions may be imposed against a Medicaid provider for reasons including but not limited to:

1. Submitting a false or fraudulent claim;

2. Failure to maintain and retain require records;

3. Failure to disclose or make available records to the Department;

4. Failure to provide and maintain the quality of services accepted within medical community standards;

5. Breach of the terms of the provider contract;

6. Submitting a false or fraudulent application for provider status;

7. Rebating or accepting a fee or charge for a Medicaid consumer referral;

8. Charging Medicaid consumers for amounts over and above the amounts paid by Medicaid; and/or

9. Failure to meet federal or state licensure or certification requirements.

REPORTING PROCEDURE--Cases of potential fraud and program abuse should be referred to the Department. All such referrals are held confidential and may be made anonymously. To make a report, call 1-800-376-1115.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: GENERAL PROGRAM ADMINISTRATION SUBJECT: Surveillance and Utilization Review (SURS)

REQUIREMENT--Federal regulations require states to develop and implement statewide surveillance and utilization control programs to promote the most effective and appropriate use of available services. Utilization control must include a post-payment review process for reviewing consumer utilization profiles and provider service profiles to identify and correct misutilization practices. The Department's Surveillance Utilization and Review Unit is responsible for claim surveillance and utilization review.

PROCEDURES--Procedures and mechanisms employed by the Surveillance Utilization and Review Unit include, but are not limited to:

1. Review of consumer profiles of service utilization;

2. Review of provider claims and payment history;

3. Computer-generated listings of duplicate payments, conflicting dates of service, and over utilization;

4. Internal checks on claim pricing, procedures, quantity, duration, deductibles, co-insurance, provider and consumer eligibility;

5. Medical staff review an application of established medical service parameters;

6. Field auditing activities; and

7. Computer-generated comparative analysis by provider type.

EXPLANATION OF MEDICAL BENEFITS (EOMB) PROGRAM--Every month the Department mails an EOMB to randomly selected consumers. The EOMB details services paid in the consumer's behalf during the previous month. The consumer is requested to verify the receipt of the services and return the form. If a consumer contacts the provider about an EOMB, the provider should refer the consumer to the Department's Surveillance Utilization and Review Section.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: GENERAL PROGRAM ADMINISTRATION SUBJECT: Medicaid Management Information System (MMIS)

DEFINITION--The Medicaid Management Information System (MMIS) is an automated system of claims processing and information retrieval required to be used by State Medicaid Programs. It includes information on Medicaid providers, consumers, and claims. Data regarding the Personal Assistance Services Program include date, type, amount, frequency, and cost of services, consumer identification, and payment category.

USE OF MMIS DATA--MMIS data are also used to produce utilization data and management information about Medicaid consumers and services.

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Department of Public Health and Human Services	**SECTION:** GENERAL PROGRAM ADMINISTRATION
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SUBJECT:** Quality Improvement Process

"Quality in health care" means doing the right thing, at the right time, in the right way, for the right person and having the best possible results, Agency for Health Care Quality and Research.

The Department staff will perform announced quality assurance reviews on a routine basis. The purposes of the reviews are to insure that optimal services are being provided to consumers, program rules and policies are being followed, and to utilize results to improve the program.

The review is divided into two parts.

Part I: Provider Prepared Standards—This is a documentation process where the agency provides information to demonstrate compliance with specific standards. This is done prior to the onsite review at the request of the Regional Program Officer (RPO). Failure to provide the information by the deadline will stop the review process and the provider will be sanctioned. There are four specific provider standards:

1. Provider reports and follows up on all serious occurrences;

2. An annual consumer survey is conducted and the results are utilized to improve services;

3. Provider has current workers' compensation coverage, liability coverage, and auto coverage; and

4. Consumers/Consumer Representatives receive appropriate information about the program from the provider.

The RPO will review this documentation prior to the onsite visit. If clarification or follow up is required, it will be done with the agency during the onsite review. The form for Provider Prepared Standards can be found at SDPAS 915.

Part II: Department Review—Department staff will conduct an onsite review of records to determine compliance with six of the eight standards in this category. The other two standards will involve outside work to gather information regarding the quality of services delivered. The eight standards are:

1. The consumer's chart contains a current authorization from the Foundation;

2. The service plan is approved by a health care professional and reflects the corresponding profile;

3. SDRs, mileage, and nurse supervision documentation are correctly recorded on the corresponding HCFA 1500;

4. Oversight occurs at least once every 180 days;

5. Requests for amendments are within the scope of the program; (Reference SDPAS 417)

6. Required documentation is readily available and the principles of charting are followed;

7. Consumers are happy with their services; and

8. Provider has a good standing in their service area.

In reviewing charts, Department staff will be looking at general utilization patterns and not counting check marks in boxes. If a consumer is to be bathed three times per week, but the service delivery records over a one month period indicate one bath, we will ask for an explanation. If a bath is missed in a similar period of time, we will pass it over.

Below are some helpful hints for review:

1. Make sure you know where all appropriate documentation is located. Many of you keep the billing records separate, which is fine, but we need timely access.

2. Provide Department staff with private and ample workspace.

3. Spend time reviewing your own records. We are happy to see case notes that reflect changes due to oversight or error.

4. Don't be afraid to ask questions.

5. It helps to have someone that can research questions or pull additional information for Department staff when needed.

6. Submit your provider prepared standards by the deadline.

7. Understand review dates are tentative and may be moved due to staff conflicts and/or bad roads.

8. Relax. This is a learning experience for all of us. We collect lots of data that helps us make program changes.

When the review is complete, Department staff will set the date for the next review based upon review outcomes. The maximum interval is 36 months,the minimum is 90 days.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: GENERAL PROGRAM ADMINISTRATION SUBJECT: Notification of Suspected Abuse or Neglect

All persons employed by an agency participating in the Medicaid Self-Directed Personal Assistance Program are mandatory reporters of suspected abuse, neglect or exploitation. This includes self-neglect.

The Montana Elder Abuse Prevention Act requires that all incidents of suspected abuse, neglect, and/or exploitation of elderly or disabled recipients be reported immediately to the local Office of Public Assistance.

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CHARTING REQURIEMENTS

This section addresses the minimal charting requirements--

1. All entries must be legible and in ink;

2. Errors are corrected by drawing a single line through the error, initialing it, and then writing the correct entry. NEVER erase, draw multiple lines through an error or use correction fluid;

3. Ditto marks should not be used;

4. Each page should have the consumer's name on it;

5. The full date of each entry must be recorded;

6. Each entry must end with the signature or initial of the person making the entry; and

7. Entries should be made in sequence. If it is necessary to make a late entry, indicate the date of the late entry and the date of the occurrence. For example, 07/30/99 charting for 07/28/99.

RULES OF CHARTING--

1. Do not sign entries of any kind for another person.

2. Do not chart before an event occurs.

CHART CONTENTS--

1. Record pertinent observations, psychosocial and physical manifestations, incidents, any unusual occurrences or abnormal behavior;

2. Chart facts, what is seen, heard, felt and smelled. Make objective rather than subjective statements and

avoid making generalizations, vague comments and opinions.

Objective: factual, real concerned with the realities of the thing dealt with rather than the thoughts of the writer. For example: hallways have multiple boxes limiting walking space.

Subjective: conclusion resulting from the feelings of the person thinking. For example: consumer lives in cluttered home.

3. Record approaches to correcting problems identified in the consumer service plan;

4. Record all training and orientation efforts.

5. Record an opening statement when a consumer is admitted and a closing statement when a consumer is discharged from services; and

6. Record the type of contact; e.g., telephone call, office visit, home visit, etc., and specifically identify who made the contact.

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The provider agency will provide the Department a copy of the Utilization Report that identifies current consumers service utilization factors (Refer to SDPAS 908).

This report is due to the Personal Assistance Services Program Manager of the Department 10 days following the end of the provider's billing period. An example follows:

BILLING PERIOD ENDS	DUE TO DEPARTMENT
1/1 - 1/15	1/25

DO NOT SEND REPORT BASED ON ANOTHER TIME PERIOD WITHOUT CONSULTING THE PROGRAM MANAGER.

Failure to complete mandatory reports violates the Montana Medicaid provider enrollment agreement. Any provider failing to meet the imposed deadlines will have claims suspended until reports are received.

Send reports to:

Personal Assistance Program Manager
DPHHS - Senior & Long Term Care
PO Box 4210
Helena MT 59604-4210

Fax: 406-444-7743

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The consumer is responsible for the following functions under the Self-Directed Personal Assistance Services Program:

1. Complete and file all necessary documents with the provider prior to the initiation of services:
   a. DPHHS MA-156, Self-Directed Personal Assistance Services Plan/Health Care Professional Approval;
   b. DPHHS MA-159, Self-Directed Personal Assistance Services Consumer Agreement or DPHHS-MA-166, Personal Representative Agreement; and
   c. DPHHS MA-160, Self-Directed Personal Assistance Services Information for Health Care Professional.

The consumer must retain a copy of the above mentioned forms for their records.

2. Obtain authorization from a physician or health care professional to participate in the program, once every 12 months;

3. Obtain authorization from a physician or health care professional to manage health maintenance tasks, once every 12 months;

4. Develop and maintain a service plan which is based upon the completion of the consumer profile and includes:
   a. an emergency back-up plan;
   b. recruitment and training plan for personal assistants; and
   c. a supervision schedule.

5. Notify provider agency when personal needs increase or decrease in order to adjust service plan.

6. Notify provider agency when health maintenance tasks are transferred to a home health agency.

7. Personal assistant management to include:
   a. recruitment;
   b. training (Refer to SDPAS 307);
   c. scheduling; and
   d. length of employment.

8. Review and approve all Self-Directed Personal Assistance Services Service Delivery Records (DPHHS MA-158);

9. Participate in recertification every 180 days;

10. Successful completion of compliance reviews;

11. Obtain prior authorization for services where required;

12. Follow all Department rules and policies. Failure to do so may lead to termination from the program and referral to the Medicaid Fraud Control Unit; and

13. Maintain in-home records to include:
    a. Consumer Profile (DPHHS-MA-157);
    b. Plan/Healthcare Professional Approval (DPHHS-MA-156);
    c. Consumer Agreement (DPHHS-MA-159);
    d. Service Delivery Records (DPHHS-MA-158) for prior six month period.

If the consumer has a personal representative, they assume these responsibilities.

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Self-directed personal assistance services are available to a cognitively impaired individual, individuals under 18, and individuals under guardianship only when that individual has a qualified personal representative. The personal representative is required to direct the day to day care of the consumer; hire, fire, manage and train all attendants; and manage all paperwork functions. The personal representative must be immediately available to provide or obtain back up services in case of an emergency or when an attendant does not show. Additionally, the personal representative assumes all medical and related liability associated with directing the consumer's care.

If the individual is under guardianship, the appointed guardian should act as the personal representative. If the individual is under 18, the personal representative should be a parent or another responsible family member. If a personal representative determines they are unable to fulfill their role, a new personal representative must be appointed, or the consumer must be discharged from the program.

A personal representative must be an individual who understands the care needs of the consumer, has a personal relationship with the consumer, and is willing and able to fulfill the responsibilities outlined in the Self-Directed Personal Assistance Personal Representative Agreement (DPHHS-MA-166). For these reasons, it is not appropriate for individuals such as a case manager or employee of an agency to assume this role.

A personal representative is not eligible to receive reimbursement for this activity or for the provision of personal assistance services to the consumer they represent. A personal representative may act as a personal assistance attendant to another consumer.

A personal representative must sign the Self-Directed Personal Assistance Services Personal Representative Agreement (DPHHS-MA-166) prior to the initiation of services. Failure to abide by this agreement can lead to termination from the program. If a new personal representative is obtained at anytime, a new DPHHS-MA-166 needs to be signed. When a personal representative temporarily leaves the area, they are responsible for appointing someone to temporarily manage the consumer's care. A temporary personal representative does not need to sign this statement, however, the agency needs to be notified of the temporary change.

All personal representatives must receive orientation to the program, just as a consumer would.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** SERVICE REQUIREMENTS **SUBJECT:** Live-in Attendants, Family and Significant Others

The personal assistance program is designed to provide support to caregivers, but not replace them entirely. When a recipient resides with family members (including significant others) or their attendant, it is expected that they will provide the majority of household support tasks, including shopping for groceries.

Tasks which are performed as a function of the home, will not be authorized as personal assistance tasks. Meal prep shall be limited to those meals when the significant party is not available. Household tasks are limited to the recipient's area and clean up after personal assistance tasks. Shopping for groceries is not permissible, but picking up DME or pharmaceuticals will be allowed when it is not convenient to do in conjunction with grocery shopping.

This policy applies to all individuals participating in the program. (Refer to SDPAS 103.)

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SUBJECT: Services to Individuals Under Age 21

The personal assistance program is available to recipients under the age of 21*, given the following conditions:

1. Services are authorized based on age appropriateness. This should be measured by determining if in the absence of the disability the individual could perform the tasks. For example, all toddlers require assistance with bathing. Older children, however, could bathe themselves in the absence of their disability.

2. Services are not authorized to support the family home. Meal preparation is limited to those times when a family member is not available to provide the service. Household tasks are limited to clean-up after personal assistance and the child's personal space. Laundry, escort, and shopping are not available.

3. Older recipients (18 to 20) who reside on their own are not subject to this policy.

4. Personal assistance services are not available for the purpose of daycare, respite, supervision, or babysitting.

Services to children must be reviewed and prior authorized by a Regional Program Officer. (Refer to PAS 900-4.) This should occur:

1. At the time of intake/admission to the program;

2. Any time the service need changes and results in an increase in hours; and

3. At recertification time.

* This is the federal Medicaid definition of a child.

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MEDICAID ELIGIBILITY--Applicants for Medicaid must meet eligibility criteria for the appropriate assistance program. All persons applying for Medicaid must meet an income and resource test. The eligibility staff in the County Office of Public Assistance is responsible for determining initial and ongoing financial eligibility for Medicaid. Refer all questions related to the eligibility determination process for Medicaid to the appropriate County Office of Public Assistance (Refer to SDPAS 808 for a list of the county offices.)

Each month the provider agency must verify continued Medicaid eligibility for each consumer. This can be accomplished by viewing the consumer's Medicaid Identification Card, contacting the Eligibility Staff at the County Office of Public Assistance, utilizing the eligibility response system, or using the Montana Eligibility and Payment System (MEPS) via the Internet. The telephone numbers for the eligibility response system and website are:

Faxback (800) 714-0075
Voice Response (800) 714-0060
MEPS http://vhsp.dphhs.state.mt.us

FAX Back (800)714-0075	Automated Voice Response (800)714-0060
MEPS http://vhsp.dphhs.state.mt.us	ACS EDI Gateway (800)987-6719
Medifax EDI (800)444-4336 ext.2546 or 2072 www.medifax.com	Provider Relations (406)442-1837 (800)624-3958 In State (406)442-4402 Fax

If the consumer becomes ineligible, Medicaid payment terminates on the effective date of ineligibility. Verification of Medicaid eligibility is solely the responsibility of the provider agency.

It is the provider's responsibility for verifying the identity and eligibility of the cardholder by utilizing one of the above listed verification mechanisms.

ELIGIBILITY:

SUPPLEMENTAL SECURITY INCOME (SSI)--Persons receiving and/or eligible for cash assistance from the federal SSI Program on the basis of age, blindness, or disability. The Social Security Administration determines eligibility for the SSI Program.

MEDICALLY NEEDY--Other persons who meet categorical requirements related to FAIM or SSI but are not receiving cash benefits due to having income exceeding Medicaid standards. These persons may be eligible or become eligible when incurred medical expenses reduce their income to the Medically Needy income level. Eligibility for the Medically Needy Program is established monthly.

FAMILIES ACHIEVING INDEPENDENCE IN MONTANA (FAIM)--Persons who are included in a monthly grant under the FAIM Program. These individuals have **BASIC coverage** and are **NOT** eligible for personal assistance services except in the following groups:

1. Pregnant women;
2. Children under age 21; and
3. SSI recipients (aged, blind, and disabled).

These are eligible for **FULL** Medicaid services.

QUALIFIED MEDICARE BENEFICIARY (QMB)-- Persons who are eligible for Part B Medicare and who are under 200% of the poverty level are eligible to have Medicaid pay their Medicare Part B premium, deductible, and co-insurance amounts.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB)--Persons who are Part B Medicare eligible with income between 100 and 120 percent of the poverty line and have countable resources less than $4,000 are eligible to have Medicaid pay their Medicare Part B premium.

WAIVER OF DEEMING-Some persons are eligible for Medicaid through a waiver of deeming. Deeming means that the income and resources of a spouse or parents (for persons 18 years of age or younger) are considered as the income and resources of the individual in determining financial eligibility for Medicaid even though they are not actually contributed.

The requirement for deeming is waived when the consumer is eligible for the Home and Community Based Services (HCBS) Program. The waiver of deeming is effective when consumers are enrolled and receive HCBS.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES **SUBJECT:** Program Eligibility and Medical Need

REQUIREMENT: To be eligible for personal assistance services, the consumer must meet all the following criteria:

1. Be eligible for FULL Medicaid benefits. Department Eligibility Staff determine initial and ongoing eligibility for Medicaid.

2. Have a functional need for supportive services related to a medical condition, substantiated by symptoms and a health care professional's diagnosis.

3. Have services authorized by the Foundation based on unmet needs.

4. Have services approved by a health care professional.

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GENERAL PROVISIONS AND SERVICES--The Self-Directed Personal Assistance program is designed to allow cognitive and capable consumers (or their personal representative) to manage allowable attendant services. This includes a limited number of health maintenance activities. The program is designed to empower consumers to take responsibility for their services.

A personal assistant is an employee of the provider agency, however, the consumer manages the attendant's work schedule, environment, length of employment and training.

Personal assistance services must actually be furnished in the home. The only exception is when the personal assistant is accompanying the consumer to receive medical care, shop for items essential to the consumer's health care or nutritional needs, or exercise in the home setting that is a part of a daily routine for health purposes and is deemed medically necessary, e.g. as prescribed by a health care professional The exception does not apply if travel is for any other purpose, e.g., travel to church, school, to exercise programs not reimbursed by Medicaid or business meetings.

Personal assistance services to be provided to consumers under 21 years of age are authorized based on medical need, age appropriateness and family support.

Consumers who reside in the following settings are not eligible to receive self-directed personal assistance services:

1. A hospital;

2. A nursing facility;

3. An intermediate care facility for the mentally retarded;

4. A licensed personal care facility/assisted living; or

5. Group Homes, Foster Homes and Supported Living.

Personal assistance provided by a member of the consumer's immediate family is not personal assistance services for the purposes of the Medicaid Program and is not eligible for reimbursement. Immediate family includes the following:

1. Husband or wife;

2. Legal guardian

3. Conservator

4. Natural parent of a minor child (less than 18 years old);

5. Adoptive parent of a minor child;

6. Step-parent of a minor child;

7. Foster parent of a minor child;

CONSUMER LIMIT:

Each consumer is eligible for no more than 40 hours (160 units) of personal assistance services each week. The Foundation may authorize hours in excess of this limit for periods longer than 14 days, but less than 90 days. The program does not authorize over 40 hours on a continual basis.

Authorization for excess of 40 hours will be based on a consideration of the following criteria:

1. Additional assistance is required for a short time as the result of an acute medical episode;

2. Additional assistance is required for a short time to prevent institutionalization during the absence of the normal caregiver;

3. Additional assistance is required for a short time during a post-hospitalization period; or

When a consumer requires additional hours over their service limit, the provider may document the need for services so long as it is for a period of less than 14 days. Anytime the need exceeds 14 days, an Oversight Documentation form (DPHHS-SLTC-164) must be faxed to the Foundation.

PERSONAL ASSISTANCE TASKS:

Personal assistance services are supportive services tasks that are necessitated by a consumer's physical or mental impairment.

Personal assistance services vary depending on the needs and requirements of each consumer. Consumer needs and requirements are documented through the consumer profile process. Personal assistance services involve direct assistance and include the following activities:

1. Activities of Daily Living (ADL) Assistance with activities of daily living and/or personal hygiene. These activities might include, but are not limited to: bathing, dressing, grooming, toileting, transferring, positioning, mobility, meal preparation, examples of meal preparation activities include menu planning, storing, preparing and serving food, eating (including tube feedings), exercise, and assistance with medications that are ordinarily self-administered.

2. Assistance with health maintenance tasks that include urinary system management, bowel treatments, administration of medications, and wound care when authorized by a physician or health care professional.

3. Instrumental Activities of Daily Living (IADL) Household tasks and escort services must be provided only in conjunction with direct personal assistance as described above and must be directly related to a consumer's medical needs.

Household tasks include assistance with activities related to housekeeping that are essential to maintaining the consumer's health and safety in the home. Examples of household tasks include, but are not limited to, changing bed linens, light housecleaning, cleaning of medical equipment, laundering, washing dishes, and arranging furniture.

Household tasks may also include snow removal in order to maintain safe access to/from the home.

Household tasks shall not include basic homemaker services which maintain an entire household or family. **WHEN A CONSUMER LIVES WITH THE FAMILY OR A SIGNIFICANT OTHER, IT IS EXPECTED THAT THE FAMILY WILL PROVIDE MOST HOUSEHOLD TASKS SERVICES.** Household tasks may not exceed one-third of the total personal assistance hours or three hours per week. Household tasks may not be provided if no other personal assistance needs exist. Household tasks may not be authorized for the purpose of supervising the consumer

Escort includes accompanying and personally assisting consumers on trips to obtain Medicaid reimbursable medical services.

Escort services are available only to those consumers who require personal assistance services en route to or at the destination when a family member or caretaker is unable to accompany them. (Reference SDPAS 707.)

Shopping services are available to obtain items essential to the consumer's health and nutritional needs (groceries). These services are available only when a family member or caregiver is unable to provide the service.

Reimbursement for mileage is available for escort services and shopping services.

4. Personal assistance services under the Home and Community Based Services Program can include extended state plan services, socialization and supervision for health and safety reasons, as well as escort and transportation for non-medical reasons. (Reference SDPAS 709.)

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Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES

SECTION: ELIGIBILITY FOR SERVICES

SUBJECT: Service Limitations and Exclusions

SKILLED SERVICES: Services which are outside the definition of health maintenance tasks may not be performed under this program (Refer to SDPAS 103).

EXCLUDED SERVICES: Personal assistance services do not include services which maintain an entire household or family or which are not medically necessary. These include, but are not limited to the following:

1. Cleaning floor and furniture in areas consumers do not use or occupy. For example, cleaning entire living areas if the consumer occupies only one room.

2. Laundering clothing or bedding the consumer does not use. For example, laundering for the entire household rather than laundering just the consumer's clothes when family is unable or unavailable.

3. Shopping for groceries or household items consumers do not need for health or nutritional needs.

4. Attendants may not shop for items that are used by the rest of the household. . Supervision (except as allowed under the Home and Community Based Services Program), respite care, babysitting, or friendly visiting. Household tasks may not be authorized for the purpose of supervising the consumer.

5. Maintenance of pets except in the case where the animal is a certified service animal:

   a. An attendant may assist with offering food and water, letting the animal out to

exercise, and brushing/combing the animal's coat;

b. Provide non-routine bathing in circumstances where the animal needs immediate attention; and

c. These services must be absorbed in the consumer's current plan of care. No additional hours will be authorized.

6. Home and outside maintenance. For example, lawn care, window washing, and wood cutting. Snow removal is permitted only to clear a path for accessibility to vehicle or curb.

7. Habilitation services are not considered personal assistance services. Services designed to train individuals to complete functional tasks must be provided by a habilitation trainer under the Home and Community Based Services physically disabled and elderly waiver, or the developmental disabilities waiver.

SERVICES TO CHILDREN:

Personal Assistance Services are not available to relieve a parent of their child caring or other legal responsibilities. Personal assistance for disabled children may be appropriate when the parent is unqualified or otherwise unable to provide the personal assistance or the child is at risk of institutionalization unless the services are provided. In authorizing services to disabled children, the age-appropriateness of parental assistance is considered. (Reference SDPAS 710 and 712.)

Household tasks may be authorized only when the child, in absence of their physical limitations, would normally perform the task. Meal prep is limited to situations when parents are not available such as an after school snack.

For a minor child (consumer under age 18) to participate in this program, a personal representative must be utilized.

CONSUMER CAPABILITIES: The consumer must be capable of making choices about activities of daily living, understand the impact of these choices and assume responsibility for the choices, or have a personal representative residing within or outside the household willing to assist the consumer in making choices and to direct the care in the home on a consistent basis. The guidelines for personal representative can be found at SDPAS 715.

The consumer must be capable of managing all tasks related to service delivery. During the authorization visit, the Foundation will determine capacity for program participation. This includes recruitment, hiring, scheduling, training, directing, and dismissal of attendants. **Consumers who are incapable of managing these tasks will not be admitted to the program.** A personal representative may assume these responsibilities on behalf of the consumer. (Refer to SDPAS 715.)

The consumer or consumer's Personal Representative must understand that the provision of services is based upon mutual responsibility between them and the provider agency.

RESTRICTIONS: Consumers who participate in Self-Directed Personal Assistance Services are restricted from utilizing agency managed personal assistance services except when the consumer's emergency backup plan fails.

Consumers who are authorized to manage specific health maintenance tasks are restricted from utilizing skilled nursing home health services for the routine completion of such tasks.

Should the consumer's emergency back up plan fail, skilled nursing services of a home health agency may be utilized.

Tasks that are not authorized for management by the consumer, may be performed through skilled nursing services of a home health agency.

Consumers and personal representatives are required to participate in the annual review process. Missed reviews can lead to service termination.

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GENERAL RULE--Each consumer eligible for Medicaid is assigned a unique Medicaid identification number which is normally their Social Security number. Newborns are assigned a temporary ID number until a Social Security number is available.

MEDICAID IDENTIFICATION CARD--Each month the Department issues an identification card or a letter to each consumer determined to be eligible for Medicaid benefits. The identification card covers eligibility for only one month, so it is important for providers to check the card to be sure it covers the current month.

PASSPORT TO HEALTH--PASSPORT is a managed care program for Medicaid consumers. It is based on the primary care case management model of managed care. In this model, the consumer chooses a PASSPORT primary physician who acts as a "gatekeeper" for certain services, including home health. The consumer must have home health services authorized by the PASSPORT provider to be eligible for Medicaid reimbursement. Check the consumer's Medicaid card to determine if they are a PASSPORT consumer. For additional information regarding the PASSPORT program, see section XI of the General Medicaid Provider Handbook.

ELIGIBILITY INFORMATION--The County Office of Public Assistance determines Medicaid eligibility and should be contacted if there is a question about a person's Medicaid eligibility. (Refer to SDPAS 808 for a list of County Offices of Public Assistance.) Many of the county offices require eligibility inquiries to be submitted in writing. For those counties, inquiries should be made on the DPHHS-FA-456, "Provider Inquiry of Medicaid Eligibility." (Refer to SDPAS 1007.) These forms are available from ACS. Eligibility may also be verified through ACS using Voice Response 800-714-0060 or FAXBACK 800-714-0075.

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PROGRAM DESCRIPTION--When utilization of Medicaid services is excessive, inappropriate, or fraudulent, consumers are restricted (locked-in) to designated providers and/or required to obtain Department approval before receiving nonemergency services. The most commonly restricted services are physician, pharmacy, and dental.

IDENTIFICATION CARD--The Department issues special Medicaid Identification Cards that identify restricted consumers. Consumers and providers have joint responsibility for exchanging information contained on the restricted card. Information on lock-in requirements specific to a consumer may be obtained from the local County Office of Public Assistance.

PROVIDER LOCK-IN--When a restricted consumer is locked-in to designated primary providers, Medicaid payment for nonemergency services will be made only to the providers listed on the restricted card (Refer to SDPAS 1008). All other providers, including hospitals, risk being denied Medicaid payment unless the primary provider made a referral or services were for a bona fide emergency. Restricted consumers are responsible for payment of unauthorized services.

PRIOR AUTHORIZATION--Some restricted consumers need nonemergency Medicaid services authorized by the Department before receiving services. In these cases, providers must call the Surveillance/Utilization Review Unit to assure Medicaid payment for nonemergency medical or drug services.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES **SUBJECT:** Denial of Initial Services

The Mountain Pacific Quality Health Foundation will provide written notice to applicants when services are denied due to service ineligibility. An applicant is defined as an individual for whom a formal request for services has been received.

The Foundation shall send the consumer written notice explaining why the consumer is ineligible for services. (Refer to SDPAS 505.)

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES
	SUBJECT: Freedom of Choice

FREEDOM OF CHOICE OF PROVIDERS--Individuals have the right to choose among any willing and qualified self-directed personal assistance services providers.

The Foundation will distribute a list of authorized agencies during the authorization visit. Reference SDPAS 803.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES **SUBJECT:** Private Pay

GENERAL RULE--Self-Directed Personal Assistance Services are available to persons who choose to pay privately for the services. These persons are not Medicaid eligible.

PROCEDURES--The personal assistance agency develops its own policies and procedures for serving private pay individuals.

FEE SCHEDULE--Fees for private pay persons are established by the personal assistance agency. Private pay fees must not be less than what Medicaid reimburses for the same service.

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Department of Public Health and Human Services

SELF-DIRECTED

PERSONAL ASSISTANCE SERVICES

SECTION:

ELIGIBILITY FOR SERVICES

SUBJECT:

High Risk Referrals

On occasion, an individual will immediately need personal assistance services to prevent institutionalization or to resolve a hazardous home situation which places them at high risk.

When this type of referral is received by the agency, they may identify critical services, which are required to maintain the consumer's health and safety. The provider must complete the Temporary Authorization (DPHHS-SLTC-161) (Refer to SDPAS 903 for the Temporary Authorization form.)and the Overview/Referral (DPHHS-SLTC-154 page 1) and fax it to the Foundation. If the provider believes the consumer or the personal representative has the capacity to self-direct, they can be admitted under this high risk policy (SDPAS 414).

The provider agency will continue to provide critical services until the Foundation is able to complete the profile. Upon receiving the completed overview and profile, the provider agency will adjust the hours accordingly. It is not required of the agency that another onsite visit be made upon receipt of the documents from the Foundation.

Should the consumer/personal representative not pass capacity screening, participation in the self-direct program will be terminated. These consumers are authorized agency based services.

Provider agencies will not be penalized when the amount of temporary services exceed the authorization, except in cases where services provided were clearly outside the scope of the program.

Payment for services delivered outside of the scope of the program will be recovered by the Department.

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Individuals who are new to the SDPAS program
Profile type: Initial

1. Referral source collects as much of the following data as possible from consumer/ family member:

   A. Name, DOB, address, phone #, SSN, responsible party/PR, health care professional, diagnosis, synopsis of need, involvement with other services, any other relevant information.

   B. If the referral source is a SDPAS agency the following applies:

   1) The agency may, but is not required to check for Medicaid financial eligibility.

   2) Determine whether the consumer meets policy criteria for SDPAS:
      a. Does not meet criteria (does not require a help with a personal assistance task, is not Medicaid eligible, etc.)
         i. If consumer agrees that they do not meet criteria for SDPAS, the referral process stops here.
         ii. If consumer does not agree that they are not eligible for SDPAS, the agency transmits the referral (DPHHS-SLTC - 154),to the Foundation with the reason for ineligibility. Foundation verifies reason for ineligibility and notifies consumer of ineligibility, provides fair hearing rights, enters reason for denial in database.
      b. Does meet criteria for SDPAS. Agency transmits referral (DPHHS-SLTC-154, page 1) to Foundation via FAX, phone, or mail within one working day.

c. If the referral source is other than an agency the referent will provide any information they have to the Foundation.

2. Foundation inputs information from referral into database and checks Medicaid financial eligibility and sends consumer basic information on the SDPAS program. If the consumer is not currently Medicaid eligible, but has applied, Foundation will process referral as Medicaid pending. The provider must verify Medicaid eligibility prior to starting services.

3. Foundation faxes referral information to nurse coordinator.

4. Foundation nurse coordinator completes onsite review within 10 working days of Foundation receiving the referral.

5. MPQHF Nurse coordinator sends Consumer Overview and choice of agency to the Foundation.

6. Foundation inputs information into database and faxes Consumer Overview, Profile and Capacity Addendum to the consumer's agency of choice.

7. Foundation sends notice to consumer.

8 Agency determines that they are able to accept the referral. Agency makes home visit to complete intake process and completes the agency section of the oOverview.

9. Agency begins attendant services as soon as possible after insuring all necessary documents are completed.

Prescreen:

A. If a nurse coordinator's travel schedule does not allow for timely review, the Foundation may pre-

screen the consumer over the phone within 10 working days.

B. Pre-screen includes collecting demographic information, review of consumer's needs, preliminary authorization of hours and days per week of service, screen for capacity, document choice of agency and set visit date. Onsite visit is made within 20 working days of Foundation receiving the referral.

C. Foundation provides Page 1 of overview to agency of choice. Foundation notifies referral agency when the consumer selects a change in agency if a High Risk intake has occurred. Agency proceeds with step 8.

D. Foundation provides a complete overview and profile after completion of home visit.

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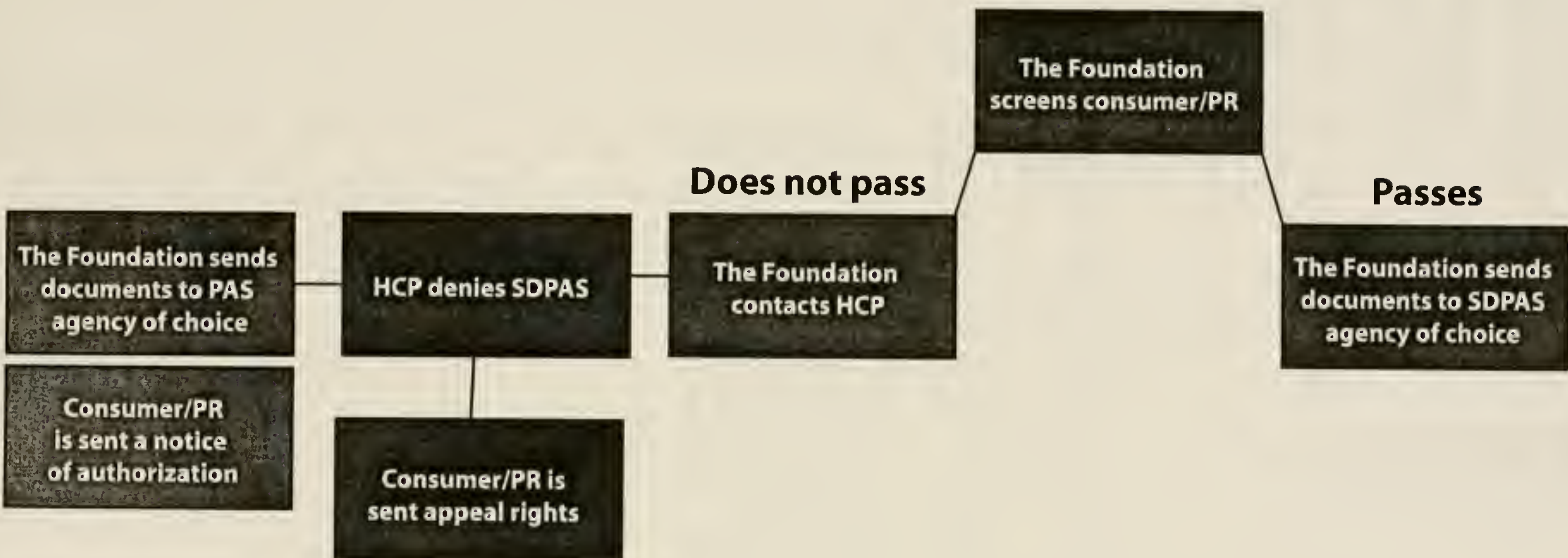
SDPAS capacity process—Annual Review



Mountain-Pacific Quality Health Foundation

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES **SUBJECT:** Request to Change Agencies

Profile type: Change

1. Consumer makes decision to change agencies.

2. Consumer contacts new agency to request services.

3. New agency contacts Foundation via the referral form (DPHHS-SLTC-154, page 1), checking the change box. New agency notifies current agency of request.

4. Foundation forwards overview and profile to new agency and enters change of agency and reason into database.

5. New agency contacts current agency to coordinate changeover and get a copy of the signed Health Care Professional Authorization (DPHHS-SLTC-160) from the consumer or a new Health Care Professional Authorization from the Health Care Professional. This form must be updated annually based on the health care professional signature date.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES **SUBJECT:** Switch in Options

A consumer wishes to move from agency based to self-directed services.
Profile type: Change

1. SDPAS agency receives referral for services from consumer/personal representative currently using agency-based services.

2. SDPAS agency instructs consumer/personal representative to contact the Foundation or submits page 1 of the Overview-Change (DPHHS-SLTC-154).

3. Foundation enters referral information into database, sends basic program information to consumer.

4. The nurse coordinator determines whether an onsite visit is necessary to complete the capacity addendum.

5. When the capacity addendum is completed and SDPAS authorized, a new overview and profile is forwarded to the self-directed agency. The new agency is entered into the database.

6. If the capacity addendum determines the personal representative or the consumer is incapable, referral is made to the RPO for follow-up education, service continues through PAS.

   Repeat the capacity after the education, and the consumer is capable, new overview and profile is sent to agency. When the capacity is repeated after the education and the consumer is incapable, a denial notice is sent.

7. Consumer may start SDPAS services when all required documentation is completed. (Refer to SDPAS 601)

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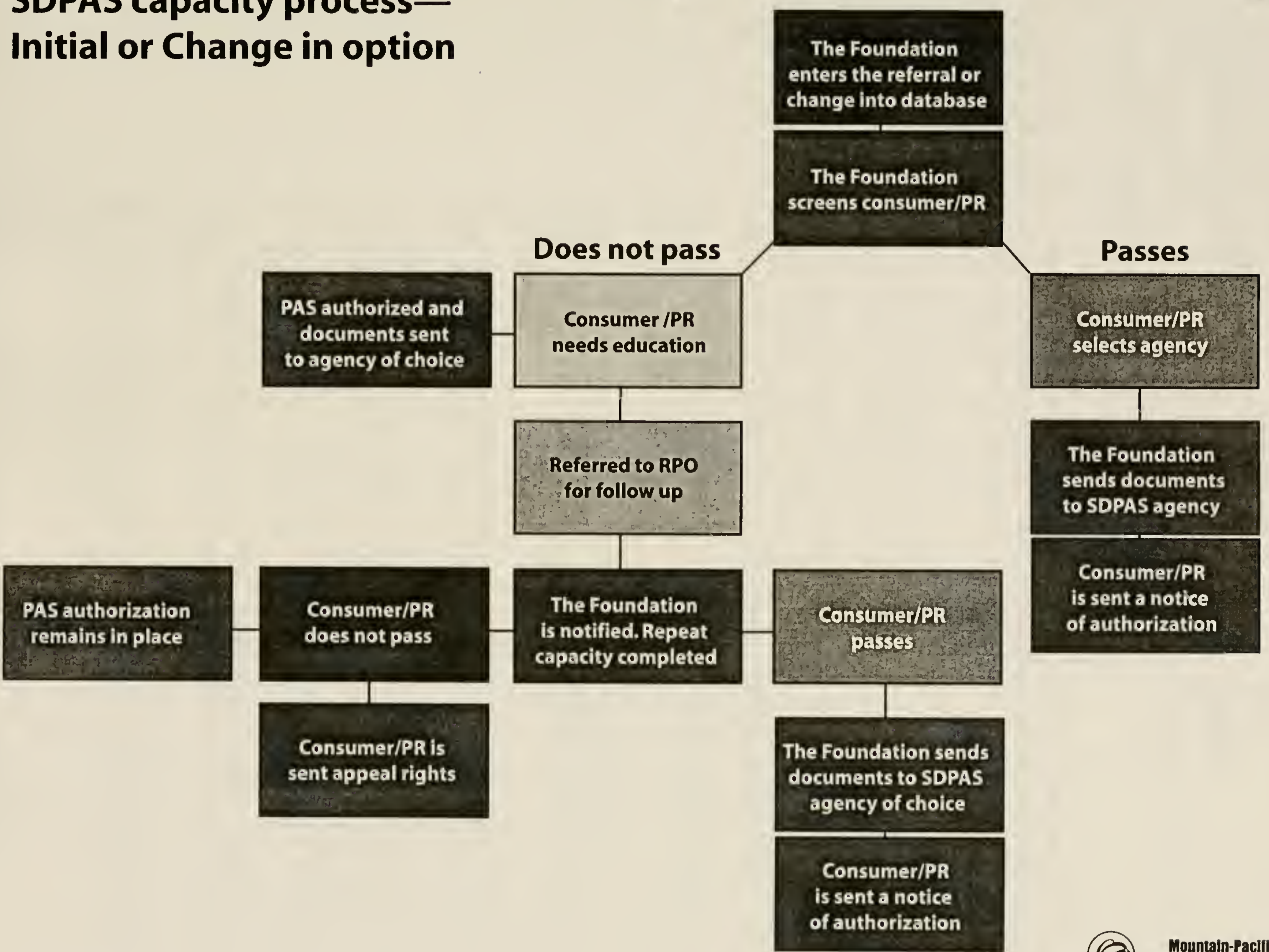
SDPAS capacity process—Initial or Change in option



Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** ELIGIBILITY FOR SERVICES **SUBJECT:** High Risk Cases

This process is for consumers who need immediate services for the purpose of maintaining their health and safety.
Profile type: Initial

1. The agency receives a referral where implementation of services is critical to prevent institutionalization or to resolve a hazardous home situation.

2. The agency sets up an onsite visit to develop a temporary service plan. The agency documents the scope (tasks and total time) and need for these services on the Temporary Authorization Form (DPHHS-SLTC-165).

3. The agency must insure the Health Care Professional Authorization (DPHHS-SLTC-160) is completed prior to service initiation.

4. The agency sends the Consumer Overview/Referral (DPHHS_SLTC-154, page 1)checked as High Risk and the Temporary Authorization Form (DPHHS-SLTC-165) to the Foundation.

5. The consumer/personal representative has 48 hours to place services in the home.

6. The Foundation follows the process for initial referrals and completes the process within 20 days. If the consumer is found incapable of directing their care, a denial notice is sent. The consumer has 30 days to select a personal representative or transition to agency-based services.

7. The consumer operates on the Temporary Authorization level until a prescreen and/or overview and profile is received.

8. When the agency receives the profile, the consumer must be noticed so any schedule changes can be developed and adjusted within 10 working days.

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Department of Public Health and Human Services	SECTION: ELIGIBILITY FOR SERVICES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Annual Reviews

Individuals who are currently receiving services require an annual review by the Foundation.
Profile type: Annual

1. Monthly, the Foundation produces a list of consumers who require an annual onsite visit.

   A. Foundation faxes list to provider agency for verification.

   B. Provider agency completes verification within 10 working days, makes appropriate corrections and/or additions and returns to the Foundation.

   C. A point sheet will be issued to providers failing to provide verification to the Foundation within 10 working days.

2. Foundation faxes verified information to nurse coordinator.

3. Nurse coordinators will contact consumers/personal representatives by telephone. This telephone contact will be utilized to determine if there is a need for an onsite review. Coordinators will review the overview and profile with the consumer or personal representative to determine whether the case needs onsite work. Situations that may warrant an onsite include:

   A. Change in environment that could affect the delivery of care.

   B. Significant change in condition or functional abilities.

   C. Communication deficit that does not allow for telephone review.

D. Increased use of equipment or specialized modifications to the home.

E. Agency/PR requests an onsite review.

4. Foundation nurse coordinator completes onsite reviews within the month the annual is due.

5. If an onsite is not warranted, the annual review will be processed by the nurse coordinator via the telephone screen.

6. Nurse coordinator sends Consumer Overview and profile to the Foundation.

7. Foundation inputs information into database and faxes Consumer Overview to the consumer's agency of choice no later than the last working day of the month.

8. Foundation sends notice to consumer when a decrease in authorization occurs.

9. Agency determines whether it is necessary to make a follow up home visit.

10. If the consumer has experienced a decrease in hours, the agency will adjust the consumer's schedule to accommodate the reduction in hours by the effective date listed on the profile.

11. If the agency and consumer believe that a medically necessary task was omitted or a general inconsistency between the profile and reality exists, the agency may notify the Foundation via an Oversight Documentation form (DPHHS-SLTC-164) to request a change in authorization. (Reference SDPAS 417.)

12. If the consumer experiences an increase in hours, the agency will adjust the consumer’s schedule per their wishes. If the consumer does not want to utilize the time that was authorized, detail the reasons on an Oversight Documentation form and submit to the Foundation.

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Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES

SECTION: ELIGIBILITY FOR SERVICES

SUBJECT: Shared Cases

Individuals who are receiving services from more than one agency.

For all contact with the Foundation, the agency providing the majority of the hours is the lead agency. The lead agency is responsible for insuring that the Foundation is aware of the name of a secondary agency. Only the lead agency will be tracked in the database.

If the time is split evenly between agencies, then the two agencies must determine which will be the lead agency.

For ANNUALS (Refer to SDPAS 415.)

When the profile is completed it will be returned to the lead agency who will forward it to the secondary agency involved.

For CHANGE IN AUTHORIZATION (Refer to SDPAS 417.)

The lead agency will request the change in authorization. The adjusted profile will be returned to the lead agency. The lead agency and the secondary agency will work together to implement the profile.

It is not necessary to contact the Foundation to request services by a secondary agency.

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Department of Public Health and Human Services	SECTION: ELIGIBILITY FOR SERVICES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Request to Amend Authorizations

Profile type - Amendment

1. Consumer, Personal Representative, or agency determines hours/services are not adequate to meet needs and the need will last for more than 14 days, and:

   A. Consumer is currently at home; post hospitalization requests should be sent upon discharge from the medical facility with a temporary authorization in place, if necessary.

   B. If additional times for household activities is being requested, it meets the one-third rule; and no more than 3 hours per week.

   C. The request is within the rules and policies of the program and is medically necessary;

   D. The consumer and/or personal representative agrees with and understands the request;

   E. Utilization and authorization levels have been compared;

   F. As the provider, you are endorsing this request.

2. The agency sends request via the Oversite Documentation form (DPHHS-SLTC-164) to the Foundation detailing why a change is needed and whether it is for short (15 to 90 days) or long term (over 90 days). The request should clearly detail medical/functional condition and must include current authorization and utilization along with the temporary authorization hours that have been implemented and support this request (DPHHS-SLTC 161). The Foundation will process the request within 10 working days. If an onsite is necessary, that visit will be made the next time the nurse is in the area.

A. Foundation staff reviews the request.

B. If pertinent information is available to process amendment, it will be handled by the Central Foundation staff.

C. If not, it will be forwarded to a nurse coordinator for processing.

1) If no onsite is necessary, the nurse coordinator completes a new profile and sends it to the Foundation to enter into database. Foundation forwards profile to the agency. The Agency is authorized to continue with the temporary authorization until the Foundation determination is received by the agency.

2) If the nurse coordinator determines that an onsite visit is necessary, the Agency is authorized to continue with the temporary authorization until the Foundation determination is received by the agency. An onsite visit will be made the next time the nurse is in that area. Following the review the necessary changes are made. The profile and overview are entered into the database. The Foundation forwards these documents to agency.

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Department of Public Health and Human Services	**SECTION:** ELIGIBILITY OF SERVICES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SUBJECT:** Health Care Professional Authorization

The Self-Directed Personal Assistance Services Health Care Professional Authorization form (DPHHS-SLTC-160) must be signed by the consumer's health care professional prior to starting services.

The consumer requests the health care professional approval by completing form DPHHS-SLTC-160. This approval must be renewed every 12 months, or at shorter intervals if requested.

The service section should always be completed with the latest information available

An individual who is employed by the consumer's provider agency shall **NOT** act as the health care professional.

The definition of a health care professional can be found in SDPAS 103.

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A personal representative is required for consumer's who have been determined incapable of directing his or her own care. Most often these are consumers that have a significant cognitive deficit, which prevents them from efficiently managing attendants. Any individual acting as a personal representative must also be screened for capacity by the Foundation. See SDPAS 715 for a complete description of the legal responsibilities of the personal representative. Incapable individuals in the absence of a personal representative are not eligible to participate in self-directed personal assistance services.

When a personal representative determines they are no longer able or willing to assume the responsibilities, they must notify the provider and subsequently, the Foundation. The provider sends an Oversight Documentation form (DPHHS-SLTC-164) stating the request of the personal representative and identifying the new personal representative. The provider should also encourage the personal representative to speak directly to the Foundation, as this will expedite the process.

If another individual is immediately replacing the personal representative, state this in the oversight form. The Foundation must verify this with the current personal representative and screen the new representative for capacity. If the resigning personal representative is not available, provide this information to the Foundation. While this is occurring the individual may remain in the self-directed personal assistance program. However, if the new personal representative does not meet capacity or declines the responsibilities, the consumer must be terminated from self-directed services and transferred to agency-based services immediately.

If the personal representative is no longer available and no replacement has been immediately identified, the provider needs to notify the RPO who will facilitate transfer of services to agency based. An Agency Discharge Sheet (DPHHS-

SLTC-158) needs to be completed upon completion of transfer of services. Any delays in this process should be clearly and sufficiently documented in the consumer's record. The consumer may transfer back to self-directed personal assistance services when a qualified personal representative comes forward.

If a consumer initially demonstrates the ability to self-direct and later provides evidence to the contrary, notify the Foundation immediately. This is the provider's responsibility. The Foundation will assist in re-screening the individual or any potential personal representative.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION **SUBJECT:** Prior Authorization Contract Requirements

As execution of the contract, the contractor is required to provide the following:

1. On-site reviews of individuals receiving personal assistance or self-directed personal assistance services for the purpose of evaluating consumers for services. These visits shall include; brief explanation of the purpose of the visit, completion of the consumer overview, completion of the consumer profile, provision of basic information regarding the program, and for the purpose of self-directed services, evaluating consumers for capacity.

2. Off-site review of requests for changes in service levels, with the option to perform an on-site review when needed.

3. Administrative support to provide process oversight to insure that referrals and profiles are being received and redistributed in a timely manner.

4. A database to provide data management with the capacity for custom reports to allow the Department to utilize consumer information for planning and projecting purposes. Report details will be determined on an as needed basis.

5. Project Manager to provide supervision oversight and technical assistance to the nurse coordinators performing the authorization work.

6. Participation in yearly training by department staff.

7. Participation in the consumer appeals process when deemed necessary.

8. Full participation in on going quality assurance. The Department will supply the quality assurance mechanism.

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As referrals are received at the central office of the Foundation, entry into the database and transmission of the referral to the nurse coordinator must occur as quickly as possible. If the referral is ineligible for services, a formal denial is sent to the consumer.

When the Foundation nurse coordinator receives a referral, they must make an onsite visit with the consumer to complete the authorization process within 10 working days from the date the referral was initially received by the Foundation. If the nurse coordinator's travel schedule does not allow for timely review, the Foundation may Prescreen within 10 working days via a telephone review. The initial onsite visit must be made within 20 working days when a Prescreen has been completed. This visit must include:

1. An explanation of the authorization process;

2. Completion of the Consumer Overview, Capacity Addendum and Profile; and

3. Distribution of literature explaining the program and available providers.

4. When necessary, distribution of the agency selection guide.

After the onsite visit is complete, the nurse coordinator faxes the completed Overview and Profile to the central office of the Foundation. The Foundation inputs the information to the database, forwards the information to the selected provider and sends notice to the consumer. At this point the authorization process is complete.

When a consumer is unable to select an agency during the onsite visit, the nurse coordinator will instruct the consumer to contact them when they have made a selection. **IT IS NOT APPROPRIATE FOR NURSE COORDINATORS TO SUGGEST, IMPLY, DIRECT OR REFER CONSUMERS TO ANY PARTICULAR AGENCY.**

CHANGE IN PROVIDER OR OPTION: At times the consumer may choose to leave one agency and receive services from a second agency or switch options.

The Foundation forwards the information to the new agency and updates the database accordingly. In cases of consumers switching to self-direct, the capacity addendum must be processed. This can be done over the telephone.

When consumers contact the Foundation regarding a change in option or provider, the delay should be explained to the consumer.

REQUEST TO AMEND AUTHORIZATION: Events may occur that require the service authorization to be increased or decreased. The provider agency will notify the Foundation when this event occurs. The Oversight Documentation form (DPHHS-SLTC-164) will be completed in this situation.

The request will be reviewed by a central MPQHF nurse and entered into the database. If sufficient information is available, a central office nurse can process the amendment.

SWITCH IN OPTIONS: If a consumer opts to enter the self-direct program and is currently receiving agency-based services, the Foundation must complete a capacity addendum. The Foundation will determine capacity and adjust the profile if HMA tasks are being added.

DEPARTMENT REQUEST: The Program Manager of the Department may at any time request that a consumer be put through the authorization process, regardless if the consumer is due for their annual review.

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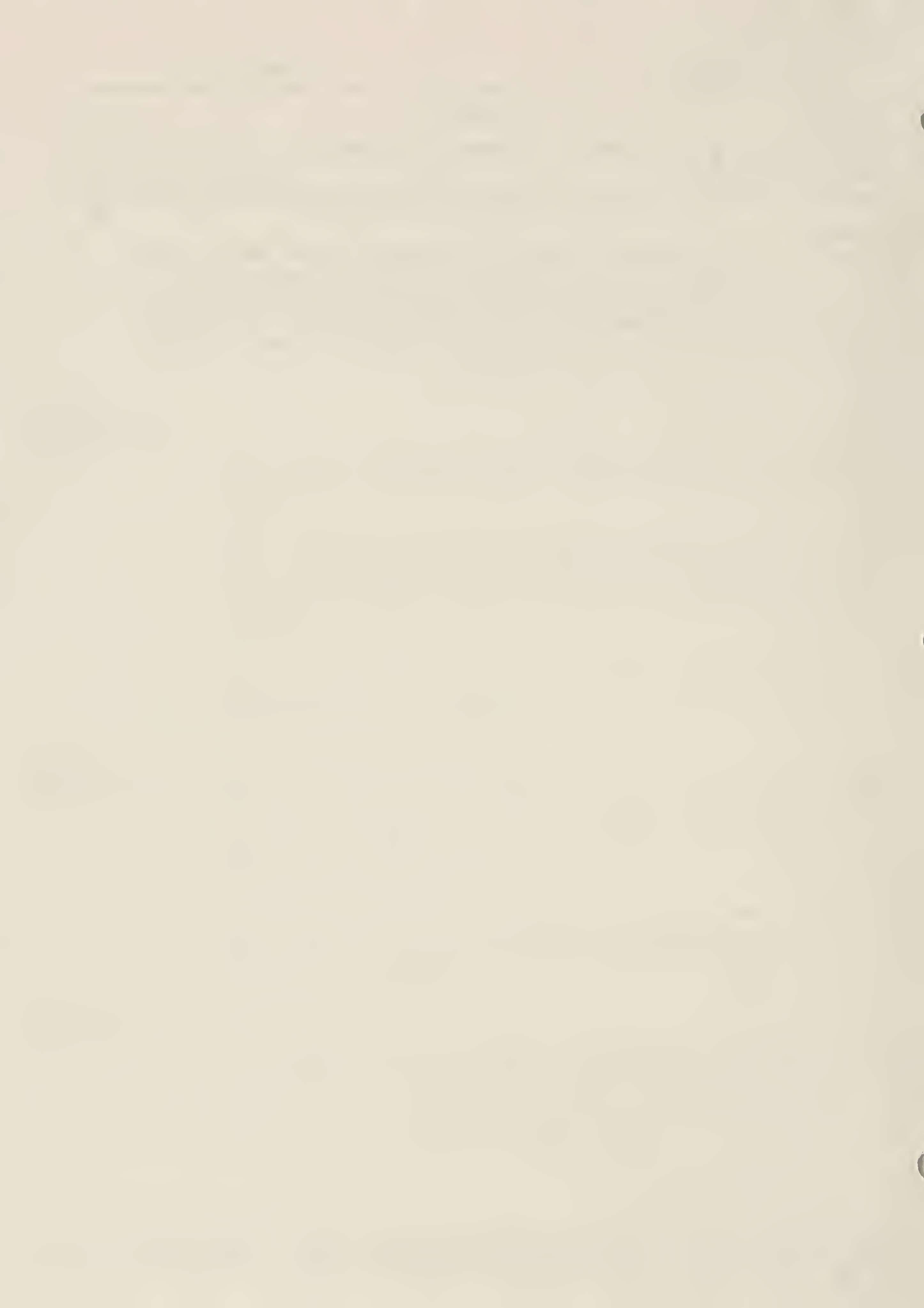

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION **SUBJECT:** Personal Assistance Services Consumer Overview/Referral (DPHHS-SLTC-154)

PURPOSE: Page 1 of this form is used as a referral document to request personal assistance services. It also lists important identifying information. Page 2 details pertinent information concerning the consumer. The agency service plan is found on page 3 of this document.

PROCEDURE: When a Personal Assistance agency receives a request for services, the agency completes the page 1 of the Overview/Referral and transmits this form to the Foundation within one working day. The Overview will be completed by the Foundation during the initial intake and at annual review.

DISTRIBUTION: The referring agency keeps a copy of the original referral. When the intake process is completed all 3 pages of the Overview will be sent to the consumer's agency choice.

INSTRUCTIONS: **NOTE TO REFERRAL SOURCE:** Fill in all information which you have. The Foundation will complete all other information during the intake process.

Check applicable boxes whether this referral is for agency-based PAS or SDPAS.

Check whether this referral is for short term services (less than 3 months), initial referral, change (for change in provider or option), readmit or inappropriate.

If a Medicaid application is pending and not approved, check the "Medicaid Pending" box.

Medicaid ID#--Enter the consumer's Medicaid number.

Name--Enter the consumer's last name, first name and middle initial.

DOB--Enter the consumer's date of birth.

Sex--Enter F for female, M for male.

Address--Enter consumer's street, city, and zip code.

Mail Address--Enter the consumer's mailing address, city and zip code if different than the physical address.

Telephone--Enter the consumer's telephone number.

Contact Person--Enter the name of the person to be contacted concerning services if other than the consumer.

Telephone--Enter the contact person's home and work telephone numbers.

Responsible Party--Enter the name of the responsible party if applicable.

Personal Representative--Check this box if the responsible party is the personal representative for the purpose of the self-directed personal assistance program.

Legal Guardian--Check this box if the responsible party is the legal guardian.

Other--Check this box if the responsible party is other than a legal guardian or personal representative and list the relationship, i.e. DPOA or POA, etc.

Address--Enter the street, city and zip code of the responsible party.

Telephone--Enter the telephone number of the responsible party.

Directions to home and other information--Enter any relevant information pertinent to the consumer or their situation which would facilitate the completion of the intake/review process by the Foundation. Include names and phone numbers of individuals other than the consumer who need to be present at the visit.

Reason for Referral--Enter any pertinent comments relating to the consumer and their need for personal assistance services.

Health Care Professional--Enter the name and the telephone number of the consumer's primary physician or other primary provider.

Primary and Secondary Diagnoses--List primary and secondary diagnoses causing the need for personal assistance.

Referral Source--Enter the name of the person completing the referral form. If appropriate enter the referring agency's name, phone number, fax number, address, city and zip code.

Date--Enter the date the request for referral is received by the referral source.

High Risk Referral--

No--Check "no" if this is not a high risk referral. Do not fill in the remaining blanks in this box.

Yes--Check "yes" if this is a high risk referral as defined in SDPAS 410.

Reason--State reason that this is a high risk referral as defined in SDPAS 410.

Date services instituted--Enter date services were instituted.

Number of days per week--Enter the number of days per week the agency is providing services under the high risk criteria.

Units per week--Enter the total units per week the agency is providing under the high risk criteria. If the date services were instituted is unknown at the time the referral is sent to the Foundation, the Temporary Authorization SLTC-161 is faxed to the Foundation to document High Risk units.

Environment--Check all statements in each box which pertain to the consumer's environment.

Sensory Status--Check one statement in each box which most closely describes the consumer's sensory status.

Page 3 For Foundation Use Only

Summary of consumer's health and reasons for authorization of care-- Describe consumer's overall health condition and reasons for authorization of care. Specify any changes in condition since the last assessment. Check which box best describes the consumer's overall health. Note any recommendations for referrals to other services.

Medications--List all medications, their dosage and route. Include oxygen and PRN medications.

Assistive Devices--Check all devices which the consumers **HAS**. Check all devices which the consumer actually **USES**.

Factors Impacting Level of Function--Check all that apply. List any other pertinent information.

Quality Assurance--Detail all situations in the space provided.

1. Commendable care delivery--Check when consumer relays or nurse reviewer observes above the call of duty care is being delivered.

2. Care issues identified-provider follow up-- Check when consumer relays issues related to staffing or delivery of services.

3. Follow up by RPO needed--Check when consumer relays a critical situation which requires immediate follow up by a department representative.

Care Determination--Nurse coordinator completes this section.

Nurse Coordinator--The Foundation nurse completing this assessment signs and enters date completed.

The Nurse coordinator completes the capacity addendum to determine if the consumer or personal representative is capable of managing personal care.

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STATE OF MONTANA
Department of Public Health and Human Services

PERSONAL ASSISTANCE SERVICES CONSUMER REFERRAL/OVERVIEW

MR#: __________

☐ PAS ☐ SDPAS
☐ Medicaid Pending
☐ Initial ☐ Readmit ☐ Short Term ☐ Annual ☐ Change ☐ Inappropriate

Medicaid ID#	Last Name	First Name M1	DOB	Sex

Street Address	City	State/Zip/County	Telephone
Mail Address	City	State/Zip/County	
Contact Person	Relationship	Telephone - Home	Telephone-Work

Responsible Party: ☐ Personal Representative ☐ Legal Guardian ☐ Other

Street Address	City	State/Zip	Telephone

Directions to home and other pertinent information:

Personal care needs:

Health Care Professional: ______________________ Telephone: ______________

List each medical diagnosis.

Primary Diagnosis	Other Diagnoses
Secondary Diagnosis	

Referral Source: PLEASE PRINT

Name	Agency	Phone	Fax
Address	City	State/Zip	Date

HIGH RISK

High Risk Referral? No ______ Yes ______ Reason? ______________________

Date services instituted: ______________ Number of days per week: ________ Total units per week: ________

ENVIRONMENT

- ☐ 1. Lives Alone
- ☐ 2. Lives with spouse or friend
- ☐ 3. Lives with family
- ☐ 4. Lives in foster or group home
- ☐ 5. Lives with Medicaid paid caregiver. Ask if it is a licensed foster home

B. Current Residence:

- ☐ 1. House, trailer
- ☐ 2. Apartment, condominium
- ☐ 3. Group Home
- ☐ 4. Shared Services ____________________
- ☐ 5. Other (specify): ____________________

C. Structural Barriers:

- ☐ 0. None
- ☐ 1. Stairs inside home which must be used for daily living
- ☐ 2. Stairs inside home optional use
- ☐ 3. Stairs leading from inside house to outside
- ☐ 4. Narrow or obstructed doorway
- ☐ 5. Kitchen not accessible ____________________
- ☐ 6. Bathroom not accessible ____________________
- ☐ 7. Other (specify): ____________________

D. Safety Hazards:

- ☐ 0. None
- ☐ 1. Inadequate floor, roof, windows
- ☐ 2. Inadequate lighting
- ☐ 3. Unsafe gas, electric appliances
- ☐ 4. Inadequate heating/cooling
- ☐ 5. Unsafe floor coverings
- ☐ 6. Inadequate stair railings
- ☐ 7. Hazardous materials exposed
- ☐ 8. Lead-based paint
- ☐ 9. Other (specify): ____________________

E. Sanitation Hazards:

- ☐ 0. None
- ☐ 1. No running water or contaminated
- ☐ 2. No toileting facilities
- ☐ 3. Inadequate sewage disposal
- ☐ 4. Inadequate food storage/refrigeration
- ☐ 5. Inadequate cooking facilities
- ☐ 6. Insect/rodents present
- ☐ 7. Other (specify): ____________________

SENSORY STATUS

A. Language Expression:

- ☐ 0. Express complex ideas, feelings and needs clearly, completely and easily in all situations with no observable impairment.
- ☐ 1. Minimal difficulty in expressing ideas and needs. May take extra time, make occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting/assistance.
- ☐ 2. Expresses simple ideas or needs with moderate difficulty. Needs prompting/assistance, errors in word choice, organization or speech intelligibility. Speaks in phrases or short sentences.
- ☐ 3. Has severe difficulty expressing basic ideas or needs and requires maximal assistance/guessing by listener. Speech limited to single words or short phrases.
- ☐ 4. Unable to express basic needs even with maximal prompting/assistance but is not comatose/ unresponsive (e.g. speech is nonsensical or unintelligible).
- ☐ 5. Patient unresponsive, unable to speak.
- ☐ 6. Age appropriate.

B. Hearing Auditory Comprehension of Language:

- ☐ 0. No observable impairment; able to hear and understand complex or detailed instructions and extended or abstract conversation.
- ☐ 1. With minimal difficulty; able to hear and understand most multi-step instructions and ordinary conversations. May need occasional repetition, extra time or louder voice.
- ☐ 2. Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting/assistance.
- ☐ 3. Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
- ☐ 4. Unable to hear and understand familiar words/common expressions consistently.
- ☐ 5. Not determined.

C. Vision

- ☐ 0. Normal vision, sees adequately including newsprint and medication labels.
- ☐ 1. Partially impaired; cannot see newsprint or medication labels; can see obstacles in path.
- ☐ 2. Severely impaired; cannot see obstacles; cannot find way around without feeling or using cane; cannot locate loose objects without hearing or touching them. Vision completely lost/essentially blind.
- ☐ 3. Not determined.

HEALTH DESCRIPTION

Describe consumer's needs:

Overall health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terminal

Medication Dosage/Route	Medication Dosage/Route	Medication Dosage/Route Include O2, PRN

ASSISTIVE DEVICES (check all that apply) H - Have U - Use

H	U		H	U	
☐	☐	Cane	☐	☐	Walker
☐	☐	Lifts - Hoyer, Other ______	☐	☐	Crutches, leg braces and other mobility devices
☐	☐	Commode chair	☐	☐	Trapeze bar, bed rails, etc.
☐	☐	Bath/Shower bench	☐	☐	Augmentative communication devices
☐	☐	Sliding or transfer board	☐	☐	Computer system
☐	☐	Environmental control unit	☐	☐	Lifeline or other emergency response system
☐	☐	Power wheelchair, scooter	☐	☐	Braille Speak, or other devices for visual impairment
☐	☐	Manual wheelchair	☐	☐	Writing splints, adapted eating utensils, other devices for impaired hand function

FACTORS IMPACTING LEVEL OF FUNCTION

ROM ☐ Upper R/L/B ☐ Lower R/L/B ☐ Fine Motor Skills ☐ Seizures ______ ☐ Endurance ☐ Pain ______

☐ Spasticity ☐ Memory LT ST ☐ Skin Integrity ☐ Cognitive ☐ Behavior ☐ Psychological ☐ Respiratory
☐ Oxygen Dependent ☐ Vent Dependent ☐ Cardiac ☐ Circulatory ☐ GI ☐ G-tube ☐ GU ☐ Neurological ☐ Muscular
☐ Neuromuscular ☐ Immunological ☐ Skeletal Other Information:

QUALITY ASSURANCE

☐ Commendable care delivery ☐ Care issues identified - provider follow up ☐ Follow up by RPO needed

Relate any care delivery issues identified by the consumer:

CARE DETERMINATION

1.	This consumer identifies his/her own needs?	☐ Yes	☐ No
2.	This consumer directs and evaluates task accomplishment (in relationship to a caregiver)?	☐ Yes	☐ No
3.	This consumer provides and/or arranges for his/her own health and safety?	☐ Yes	☐ No
4.	This consumer has the ability to report lack of care delivery (i.e., no shows)?	☐ Yes	☐ No

Nurse Coordinator: ______________________ Date: __________

Capacity Addendum

Medicaid ID#	Last Name	First Name MI	Date

Who will be directing care? ☐ Consumer ☐ Personal Representative

Personal Representative: Name	Home Telephone	Work Telephone

Mailing Address	City	State	Zip Code

Relationship to Consumer: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Adult Child
☐ Other: ____________________

How did you learn of the self-direct program/How long have you been on the program?

(Initial) Have you had experience with personal care in the past?

(Annual) Are you currently utilizing services?

How many attendants do you need to provide your personal care?

How do/will you find your attendants?

How do/will you train those attendants?

What time during the day do you need care?

What do/will you do if your attendant does not show up to provide your care?

Do you feel comfortable confronting your attendant, if problems arise?
How do/will you deal with the problem?

Identified Concerns:

Summary:

Does the individual meet the capacity to self-direct? ☐ Yes ☐ No, referred to RPO for education ☐ Yes on rescreen

Nurse Coordinator: ☐ Onsite ☐ TC Date:

Department of Public Health and Human Services	SECTION: MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Personal Assistance Services Profile (DPHHS-SLTC-155)

PURPOSE: To provide an instrument for collecting and documenting essential information needed to establish the consumer's functional limitations and ability to perform ADL-activities of daily living, IADL-instrumental activities of daily living household tasks and HMA-health maintenance activities (Self-Direct option only).

To document information on service planning issues for personal assistance services.

To provide a worksheet for determining the weekly units needed by the consumer.

PROCEDURE: The Profile must be completed by the Foundation Nurse Coordinator at the initial intake for services, at the annual review, and whenever a significant change in the consumer's condition occurs causing the service need to change.

INSTRUCTIONS: Check whether this review is for agency-based Personal Assistance Services (**PAS**) or Self-directed Personal Assistance Services (**SDPAS**).

Check appropriate program if the consumer is receiving Home and Community Based Services (HCBS): **Physically Disabled** (under age 65), **Elderly** (65 and older) or **DD** (Developmentally Disabled).

Check **Other Service** if the consumer is receiving any other supporting service and **list** the service.

Check whether this review is the **Initial** review, **Annual** review or an **Amendment**. If this is an amendment, check whether it is for **Permanent** or **Short Term**. If the review results in a **Denial**, check this box. If the amendment required an **Onsite** visit, check this box.**Nurse Coordinator** signs and enters **Date** the profile was done.

Effective Date--The date of the screen or if there is a reduction in units, 30 days from the date of the screen. If the profile is an approved amendment the effective date is the date the amendment was received at the Foundation. Consumer's Medicaid number--Enter consumer's Medicaid ID number.

Consumer Name--Enter the consumer's full name.

Companion Case Name--Enter the name of a person (if any) residing in the same household who is also receiving personal assistance services.

Relationship--Enter the relationship of the companion case to the consumer.

Level of Impairment--Rate the consumer's impairment level according to the following scale for each task listed:

0 = Independent: No functional impairment. The individual is able to conduct the activities without difficulty and has no need for assistance. Need is met with adaptive equipment or service animal.

1 = Standby: Mild functional impairment. The individual is able to conduct the activity but does require standby assist or cuing.

2 = Limited Assist: Moderate functional impairment. The individual is able to conduct the activity with moderate difficulty and requires minimal assistance.

3 = Extensive Assist: Severe functional impairment. The individual has considerable difficulty completing the activity and requires extensive assistance.

4 = Total Dependence: Total functional impairment. The individual is completely unable to carry out any part of the activity.

5 = N/A Age Appropriate: The individual's ability to participate in and/or complete the task is consistent with average person of that age.

The nurse coordinator must decide which of the six impairment levels best describes the consumer being reviewed. An impairment in this context is a functional limitation, i.e., a limitation in the ability to carry out an activity or function. A person has an impairment with respect to a particular activity if he is limited, either physically or mentally, in his ability to carry out that activity. "0" and "4" are absolutes in the sense that they indicate no functional impairment or total dependency. For example, if a consumer can perform any of the dressing tasks for himself, a "4" is not appropriate. If he can perform the dressing task without difficulty, a "0" is appropriate. If a consumer is able to conduct an activity only with difficulty, and the difficulty is such that the consumer frequently cannot complete some part of the activity, then the consumer is impaired, even if the consumer at other times can complete the entire activity. In addition, if the degree of difficulty is such that the consumer should have at least minimal assistance with that activity, then the consumer is impaired, even if the consumer can (with difficulty) conduct the activity without assistance. If the consumer can complete the activity but needs cuing to do so, or, because of safety considerations needs someone there while completing the task, they would require standby assist. If the difficulty with an activity does not affect the consumer's conduct of the activity or does not cause any problems for the consumer, the consumer is not impaired.

<u>Enter a level for each task.</u>

The Personal Assistance Services Profile is designed to rate a consumer's level of independence in self-care. Determine the level for each task according to the ability to self-care and not according to the consumer's access to a resource to assist with the task. In rating each item, use the consumer's response, observations of activity, and any knowledge provided

about the consumer from other sources. To determine the severity of the consumer's impairment, consider the following factors:

1. Consumer Perception of the Impairment--Does the consumer view the impairment as a major or minor problem?

2. Congruence--Is the consumer's response to a particular question consistent with the consumer's response to other questions and, also, consistent with what is observed?

3. Consumer History--Probe for an understanding of the consumer's history as it relates to the current situation and of the consumer's attitude about the severity of the impairment. Has the consumer always lived in a cluttered home and is not, therefore, concerned because he is unable to perform housekeeping tasks? Has the consumer always eaten only one meal a day and is not, therefore, interested in eating more often? How has the impairment changed the consumer's lifestyle?

4. Consumer's Right to Self-Determination vs. Danger to Self--Consider the consequence to the consumer if he chooses not to take medications, bathe, adhere to a special diet, etc.

5. Lack of Facilities--Absence of facilities for bathing, laundry, telephoning, or meal preparation may indicate an impairment. The impairment and its degree will depend on accessibility to the facility, on the consumer's ability to use the facility, and on the consumer's ability to make satisfactory accommodations in the absence of the facility.

6. Adaptation--If the consumer has adapted his physical environment or clothing to the extent that he is able to function without assistance, the degree of impairment will be lessened, but the

consumer will still have an impairment. This includes the use of adaptive equipment.

Use the following examples for each item to help you differentiate between scores of "2" or "3".

	2 -Limited Assist	3 = Extensive
1. Bathing	Consumer may set out supplies. Consumer may accomplish bath by using a chair or other adaptive device for assistance. Consumer may need help with drawing and testing temperature of water	Consumer needs help getting in and out of tub or shower. Consumer needs help with actual bathing of body due to inability to reach or grasp. Consumer always needs adaptive devices or can only manage sponge baths due to disabilities. Consumer cannot haul or manage heating of water in a home without modern conveniences.
2. Dressing	Consumer needs *occasional* help with zippers, buttons, or putting on shoes and socks. Consumer may need help laying out and selecting clothes.	Consumer needs help with zippers, buttons, or shoes and socks. Consumer needs help getting into garments, that is, putting arms in sleeves, legs in pants, or pulling up pants. Consumer may dress totally inappropriately without help or would not finish dressing without physical assistance.
3. Hygiene	Consumer may set out supplies. Consumer may accomplish tasks an adaptive device for assistance.	Consumer needs to have help with shaving *or* shampooing, etc., because of inability to see well, to reach, or to successfully use equipment. Consumer needs someone to put lotion on body or to comb or brush hair.
4. Toileting	Consumer has instances of urinary incontinence, and needs help because of this from time to time. Fecal incontinence does not occur unless consumer has a specific illness episode. Consumer may have catheter or colostomy bag, and occasionally needs assistance with management.	Consumer often is unable to get to the bathroom on time to urinate. Consumer has occasional episodes of fecal incontinence. Consumer may wear diapers to manage the problem and needs some assistance with them. Consumer usually needs assistance with catheter or colostomy bag.

	2 -Limited Assist	3 = Extensive
5. Transfer	Consumer usually can get out of bed or chair with minimal assistance..	Consumer needs hands-on assistance when rising to a standing position or moving into a wheelchair to prevent losing balance or falling. Consumer is able to help with the transfer by holding on, pivoting, and/or supporting himself
6. Positioning	Consumer is usually capable of positioning themselves but with some difficulty and requires occasional, light assist.	Consumer requires consistent assist with positioning, but they are capable of participating in the task by holding on and/or helping to move themselves while being assisted.
7. Mobility	Consumer walks alone without assistance for only short distances. Consumer can walk with minimal difficulty using an assistive device or by holding onto walls or furniture.	Consumer has considerable difficulty walking even with an assistive device. Consumer can walk only with assistance from another person. Consumer never walks alone outdoors without assistance. Consumer may use a wheelchair periodically.
8. Meal Preparation	Consumer can only fix meals that require simple preparation. Consumer can usually open cans and heat food, use microwave or oven, prepare some vegetables, cook eggs and small cuts of meat. Consumer may have difficulty with cutting meats or other foods for preparation.	Consumer can only prepare simple cold foods like sandwiches, purchase snacks and cereal, or warm-up food prepared by others, Consumer has difficulty opening cans and preparing fresh foods for cooking. Consumer regularly has difficulty seeing or turning burner on and off and sometimes forgets to turn burners off.
9. Eating	Consumer may need occasional physical help. Consumer eats with adaptive devices but requires help with their positioning	Consumer usually needs extensive hands-on assistance with eating. Consumer may hold eating utensils but needs continuous assistance during meals. Consumer would not complete meal without continual help. Spoon feeding of most foods is required, but consumer can eat some finger foods.
10. Exercise	Consumer may need occasional assistance in completing exercise routine. Consumer may need occasional support or guidance.	Consumer needs some assistance in completing exercise routine. Consumer needs support or guidance.

	2 -Limited Assist	3 = Extensive
11. Medication Assistance	Defined as: Assistance with already set up meds. Consumer is compliant with taking meds but may need reminders. Consumer may require docu-dose or setup by home health, but meds can safely be kept accessible to consumer.	Consumer may be non-compliant and/or require constant reminders and supervision. It may be necessary to keep meds in a secure place such as a locked box.
* 12. Bowel Program	Consumer may need occasional assistance with suppository.	Consumer requires assistance with on-going bowel program.
* 13. Wound Care	Consumer may need occasional help with reddened areas. Consumer may need some help with dressing changes but is able to assist in the care themselves.	Consumer has on-going problem with decubiti and is unable to do self-care. Consumer requires help post-op with dressing changes and is unable to assist with self care.
* 14.Urinary System Management	Consumer needs occasional help with self-cath or catheter care. .	Consumer needs on-going help with catheter care, insertion, etc. Consumer is unable to contribute meaningful assistance to complete task. Consumer needs assistance with colostomy care.
* 15. Medication Administration	Defined as: , identifying right medication, right dosage, right time of day and right route of administration. Consumer is able to take some medications independently.	Consumer requires assistance with all medication administration.
16. Medical Escort	Consumer requires intermittent or minimal assistance with ambulation, transfer, (un)dressing or toileting en-route to or while at the medical appointment. Consumer does not have family or caregiver to assist.	Consumer requires assistance with two or more; ambulation, transfer, (un)dressing or toileting en-route to or at the medical appointment. Consumer does not have family or caregiver to assist.
17. House Cleaning	Consumer can do most tasks around the house, like picking up, dusting, washing dishes, sweeping, straightening the bed, carrying out trash, light vacuuming, or cleaning sinks. Consumer cannot move heavy furniture or do extensive scrubbing or mopping.	Consumer is able to do only very light housework like dusting, washing a few dishes, or straightening up magazines/ newspapers. Consumer cannot see well enough or does not have the strength or flexibility to sweep floors, change bed linens, or carry heavy objects.

	2 -Limited Assist	3 = Extensive
18. Laundry	Consumer does hand washing but has difficulty wringing and hanging heavy laundry to dry. Consumer may be able to put clothes in washing machine, sort clothes, fold them, and put them away with only minimal difficulty. Consumer can also assist in these ways if a Laundromat is used. Consumer may have strength but may not be able to see or turn washer dials, or may require supervision or instruction to use a washer.	Consumer may do light hand washing but cannot bend or lift or carry loads of clothes to manage most laundry. Consumer cannot hang clothes out at all or get them off a line, but may fold them and help put them away. Consumer may not be able to wring out clothes without help. If a Laundromat is used, the consumer has considerable difficulty using it.
	* Self-Directed Only	
19. Shopping	Consumer decides what to buy and can shop if someone goes along to help. Consumer may shop by telephone. Consumer may have difficulty carrying or storing groceries.	Consumer may still decide what to buy, but seldom, if ever, goes to a store. Consumer may not be able to shop by telephone due to communication difficulties. Consumer regularly cannot carry or store most of the purchases without help.

Check the appropriate column that indicates the degree to which the consumer's need for help in the completion of each task is met. Check one column for each task.

M = Met--The consumer's needs are met. The consumer may be independent in this task, or the need for help is being met by someone other than a personal assistance agency. Other sources for meeting the need include family, friends, Council on Aging, home health, etc. No time can be authorized for any task coded with an "M".

P = Partially Met--The consumer requires help with the task. Someone other than a personal assistance agency is providing that help part of the time, or the consumer may participate in the task. For instance, an individual requires help with meal preparation. A family member is able to cook breakfast and dinner, but is not available to cook lunch.

U = Unmet--The consumer requires help with the task and the need is currently unmet.

Activities of Daily Living Tasks (ADL)
For each task, check any applicable sub-task listed.
NOTES:

Meal Preparation--Meal preparation is for the consumer only, not other members of the household.

If the Medicaid paid caregiver lives in the same household as the consumer, time should not be authorized for meal preparation except for tasks related to a medically necessary specific diet; i.e., puree, cooking a separate meal when family members unable or unavailable.

Medication Assistance--Time for this task may be allotted only when no other task is being provided.

Minutes Per Day--For each task to be authorized, enter the daily number of minutes needed to conduct that task.

Days Per Week--For each task to be authorized, enter the number of days per week the consumer will require assistance with the task.

NOTE: For consumers who require assistance with bathing, the norm for authorization is three times per week. If a consumer demonstrates a lesser need, authorize accordingly. If a consumer is medically compromised by bathing three times per week, authorize at a higher level. The consumer must have a specific medical condition that is directly compromised by less bathing in order to increase the authorization. The foundation will document medical necessity on all exceptions with a statement from the healthcare professional. Statements obtained by the provider agency are not acceptable.

Total Minutes--Multiply the minutes per day times the days per week to obtain the total minutes per week for each task.

Health Maintenance Activities (HMA)
NOTE: This section to be used for SDPAS only.

Minutes Per Day--For each task to be authorized, enter the daily number of minutes needed to conduct that task. A task may be authorized if the provider performs it at least once a month.

Days Per Week--For each task to be authorized, enter the number of days per week the consumer will require assistance with the task.

Total Minutes--Multiply the minutes per day times the days per week to obtain the total minutes per week for each task.

Medical Escort--Do not enter the amount of time to be utilized. A provider must document mileage, destination, and time when escort services are utilized. Consumers must require cuing and/or redirecting because of cognitive deficits, or hands on assistance with ambulation, transfer, (un)dressing or toileting en route to, or while at, the medical appointment in order to qualify for this service. Transportation alone is not a qualifying task for admission into personal assistance services or self-directed personal assistance services. The consumer must get prior authorization for state plan transportation by calling 1-800-292-7114.

IADL- instrumental activities of daily living Household Tasks (HT)
NOTES:

Cleaning, Laundry, Shopping--Estimate the amount of time needed to complete these tasks. When a consumer lives with a family, it is expected that the family will provide most household, shopping and escort services. When a consumer lives with the Medicaid-paid caregiver, time should not be authorized for shopping and general household chores. Consider area used by consumer, actual time required to complete task. Multi-tasking is to be utilized when environment

factors allow; i.e., laundry can be washed while cleaning consumer's bedroom.

Comments--Provide comments relative to the need for delivery of services. Be clear and concise.

Provider--Nurse coordinator enters the name of the provider the consumer choose to provide services.

Date Provider Selected-- Original date the provider was selected.

NOTE: Remember only authorized tasks and frequency will print on provider's profile.

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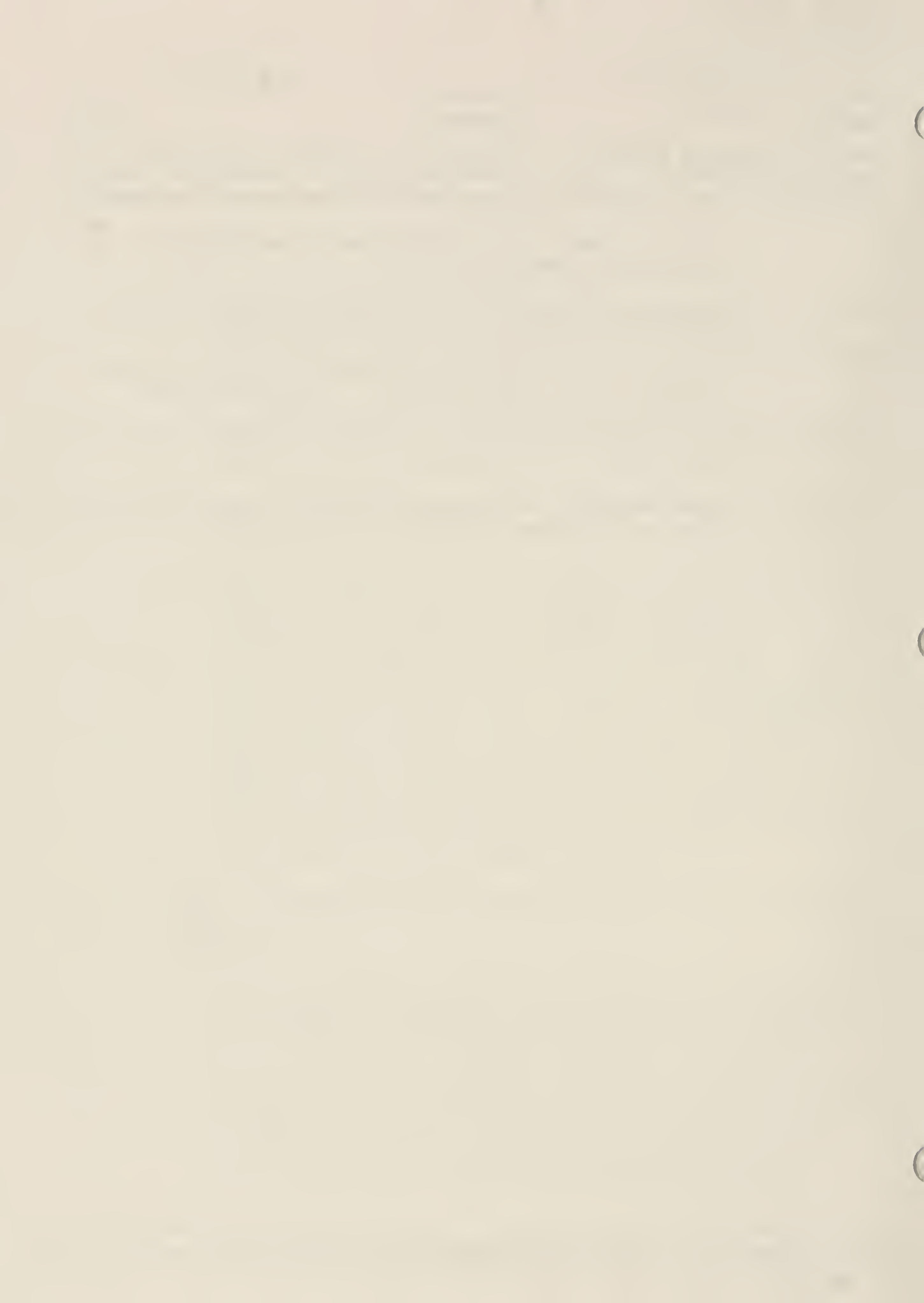

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION
	SUBJECT: Self-Directed Personal Assistance Services Authorization (DPHHS-SLTC-152)

PURPOSE: This form notifies the applicant of the results of the screening for the Personal Assistance Program. This form also provides the applicant with their fair hearing rights.

PROCEDURE: The Foundation completes this form for all initial personal assistance services authorizations, decreases in authorizations, and denials.

DISTRIBUTION: The applicant receives the original by mail. A copy is retained by the Foundation.

INSTRUCTIONS: Applicant--enter the applicant's name, address, city, zip code and social security number.

Screening Determination--Enter the date the applicant was screened and check the appropriate authorization.

Applicant Choice of Agency--List the applicant's choice of agency. If the applicant has not yet made a choice, leave blank.

Authorization--Fill in the number of units authorized for Activities of Daily Living (ADL) and Household Tasks(IADL). List total number of units and convert to hours. Enter authorized span date.

Reviewer--Reviewer name and dates completed.

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STATE OF MONTANA
Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES AUTHORIZATION

Name of Applicant

Street Address

City and Zip Code   Social Security No.

Mountain Pacific Quality Health Foundation
3404 Cooney Drive
Helena, MT 59602

Phone: 1-800-268-1145 / 443-4020
Fax: 1-800-268-5767

SCREENING DETERMINATION:

On you were screened to determine if you are eligible for Self-Directed Personal Assistance Services. The decision of the screening professional is:

Self-Directed Personal Assistance Services **ARE NOT** required and **WILL NOT** be paid by Medicaid. If Medicaid payment is currently being made for Self-Directed Personal Assistance Services, reference **authorized span** listed below for end date .

Self-Directed Personal Assistance Services are required and Medicaid will pay if you have full Medicaid eligibility, reference authorized span. Should you continue to need service, contact your Agency and you will be rescreened. prior to the ending date. Contact your local Office of Human Services, if you have questions regarding financial eligibility.

A change in the level of authorization has occurred.

Authorization for Self-Directed Personal Assistance Services has been denied. You do not meet program eligibility criteria. Agency based Personal Assistance Services may be available.

If you have not entered Self-Directed Personal Assistance Services and determined financially eligible within 60 days of the screening date, this screening determination is no longer valid.

APPLICANT'S CHOICE OF AGENCY:

1.

2.

ADL: + HT: + HMA: = HRS

Authorized Span: To:

Reviewer:

Name

Date

LEGAL BASIS for ACTION:
PERSONAL ASSISTANCE SERVICES
ARM 37.40.1301-1315
42 CFR §440.167

If you are financially and medically eligible for Personal Assistance Services, you may request services from any eligible and willing provider. Contact your provider agency or telephone the Mountain Pacific Quality Health Foundation (address, phone above) or the Regional Program Officer in your area, if you have any questions or concerns regarding this authorization.

IF YOU DISAGREE WITH THIS DETERMINATION, YOU MAY REQUEST A FAIR HEARING. PLEASE READ THE SECOND PAGE OF THIS NOTICE FOR FURTHER INFORMATION ON THE FAIR HEARING PROCESS.

I request a fair hearing for these reasons: ____________________

____

____

____

I have an attorney: [ ] YES [ ] NO

My attorney's name is: ____________________

Attorney's address: ____________________

Attorney's phone number: ____________________

____________________ ____________ ____________
(Claimant or Authorized Representative) (Phone) (Date)

To request a fair hearing complete, sign and mail the white copy of this notice to: Hearing Officer, P.O. Box 202953, Helena, MT 59620.

Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, disability, sex or marital status.

If you feel that you have been discriminated against, you may contact the Department of Public Health and Human Services for information on how to file a complaint.

IMPORTANT

If you disagree with the determination stated on this form you may request a fair hearing before a hearing officer of the Board of Public Assistance.

Under certain circumstances you may continue to receive services during the period of your appeal. A request for continuation of services must be made prior to the date given in the notice of the change in or termination of your services. If you are interested in continuing to receive services during the period of your appeal, you must contact one of the regional offices immediately to request continuation of services. If you lose your appeal, you will be fiscally responsible for services delivered during the appeal process.

A request for fair hearing must be made in writing within 90 days of the mailing date of this notice. You may use the "Request for Fair Hearing" section on the front section of this form to make your request. A request for fair hearing must be directed to:

Hearing Officer
P.O. Box 202953
Helena, MT 59620

If you need assistance in preparing a request for fair hearing you may contact one of the regional offices listed below.

Prior to the fair hearing, a program officer for the Department will conduct an administrative review of the matters which you are appealing. The administrative review is an opportunity for you to informally present your case and for the Department to reconsider the matters that you are appealing.

The fair hearing is a process in which the parties formally present their legal arguments and evidence in support of their positions on the matters at issue. The decision of the hearing officer is made based on the evidence presented at hearing and upon the governing federal and state laws, regulations and policies. The decision of the hearing officer may be appealed to the Board of Public Assistance. The Board of Public Assistance reviews the matters at issue as presented before the hearing officer. This appeal does not involve another hearing. The decision of the hearing officer or the Board of Public Assistance resolves the matters at issue and is binding upon the parties unless an appeal is made to state district court.

REGIONAL PROGRAM OFFICERS

Office	Counties
Regional Program Officer 2121 Rosebud Drive Suite D Billings, MT 59102 Phone: 655-7646 655-7635	Big Horn, Carbon, Golden Valley, Musselshell, Stillwater, Treasure, Wheatland, Yellowstone
Regional Program Officer 220 W. Lamme, Suite 1E Bozeman, MT 59715 Phone: 586-4089	Gallatin, Madison, Park Sweetgrass
Regional Program Officer 700 Casey Butte, MT 59701 Phone: 496-4989	Beaverhead, Deer Lodge, Granite, Silver Bow, Montana State Prison
Regional Program Officer 218 West Bell, Ste 205 Glendive, MT 59330 Phone: 377-6252	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, Wibaux
Regional Program Officer 201 1st St S Great Falls, MT 59405 Phone: 453-8902 453-8975	Blaine, Cascade, Choteau, Fergus, Glacier, Hill, Judith Basin, Liberty, Petroleum, Phillips, Pondera, Teton, Toole
Regional Program Officer 3075 N. Montana Ave P.O. Box 202958 Helena, MT 59620 Phone: 444-1707	Broadwater, Jefferson, Lewis & Clark, Meagher, Powell, MT State Hospital Long Term Care Unit
Regional Program Officer 2282 Hwy 93 S P.O. Box 2357 Kalispell, MT 59903 Phone: 755-5420	Flathead, Lake, Lincoln,
Regional Program Officer 2677 Palmer, Suite 240 Missoula, MT 59808 Phone: 329-1312 329-1310	Mineral, Missoula, Ravalli, Sanders

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION
	SUBJECT: Contract Performance Standards

The following performance standards will determine the actual performance of the contracted duties. Each standard is measurable based on contracted terms or department rules and policies.

1. Referral to authorization time is less than 20 working days ninety-five percent (95%) of the time.

2. Management reports are completed and delivered to the Department by the 20th of each month one hundred percent (100%) of the time.

3. A core group of individuals authorizing services is less than ten (10), and experiences a less than 20% turnover.

4. Authorizations are in accordance to policy 95% of the time.

5. Actual contract costs are proportionate to contract fees.

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Department of Public Health and Human Services	SECTION: ADMINISTRATIVE REQUIREMENTS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Consumer/Personal Representative Responsibility

The consumer/personal representative is responsible for the following functions under the Self-Directed Personal Assistance Services Program:

1. Complete and file all necessary documents with the provider prior to the initiation of services:
   a. DPHHS SLTC-159, Self-Directed Personal Assistance Services Consumer Agreement or DPHHS-SLTC-166, Personal Representative Agreement; and
   b. DPHHS SLTC-160, Self-Directed Personal Assistance Services Health Care Professional Authorization.

These documents must be on file prior to service initiation in order for services to be payable.

The consumer must retain a copy of the above mentioned forms for their records.

2. Obtain authorization from a physician or health care professional to participate in the program, once every 12 months;

3. Obtain authorization from a physician or health care professional to manage health maintenance tasks, once every 12 months;

4. Develop and maintain a service plan which is based upon the completion of the consumer profile and includes:
   a. an emergency back-up plan;
   b. recruitment and training plan for personal assistants; and
   c. an oversight schedule.

5. Notify provider agency when personal needs increase or decrease in order to adjust service plan.

6. Notify provider agency when health maintenance tasks are transferred to a home health agency.

7. Personal assistant management to include:
   a. recruitment;
   b. training (Refer to SDPAS 706);
   c. scheduling; and
   d. length of employment.

8. Review and approve all Self-Directed Personal Assistance Services Service Delivery Records;

9. Participate in recertification every 180 days;

10. Successful completion of compliance reviews;

11. Participate in prior authorization activities for services;

12. Follow all Department rules and policies. Failure to do so may lead to termination from the program and referral to the Medicaid Fraud Control Unit; and

13. Have knowledge of where the following records are held:
    a. Profile (DPHHS-SLTC-155);
    b. Consumer Agreement (DPHHS-SLTC-159); and
    c. Service Delivery Records.

    If the consumer has a personal representative, the PR assumes these responsibilities.

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SUBJECT:
Provider Eligibility/
Responsibility

ELIGIBILITY: Provider agencies must meet established Medicaid criteria and be recognized as an organized business in the State of Montana.

Enrolled providers must successfully complete Quality Assurance Reviews by Department staff to remain an active provider.

RESPONSIBILITY:

The provider agency is responsible for the following functions under the Self-Directed Personal Assistance Services Program:

1. Document and verify Medicaid eligibility on a monthly basis;

2. Assist the consumer with required paperwork during an onsite home visit with the consumers;

3. Provide payroll functions for personal assistants;

4. Provide the consumer with:

   a. program enrollment information;
   b. program philosophy and department policies;
   c. complaint procedures;
   d. forms for ongoing participation; and
   e. procedure to have a personal assistant hired by the provider agency.

5. Complete recertification at intervals not exceeding 180 days or when there is a significant change in the functional needs of the consumer. The recertification consists of:

   a. recertifying program eligibility;

b. review the Consumer Profile, if necessary - refer to Foundation for amendment;
c. review the service plan and personal assistant schedule;
d. assist the consumer to evaluate personal assistant, if necessary; and
e. changes in program policy.

6. File reports as required by the Department (Refer to SDPAS 311);

7. Successful completion of provider compliance reviews; and

8. Insure consumer/personal representative are abiding by the Consumer Personal Representative Agreement.

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The Department will enroll providers that are businesses organized under the laws of the state of Montana, and meet Montana Medicaid requirements.

A provider enrollment application may be obtained by calling Consultec, Inc at 1-800-624-3958.

A description of the provider's service area must accompany the application. A service area must be defined in terms of a county or Indian Reservation. Anytime the provider amends the service area, the department must be notified.

Newly enrolled providers must receive in service training by a Regional Program Officer prior to accepting consumers into the program.

In addition, the Regional Program Officer may require preapproval of new Service Plans until the agency demonstrates understanding of department policies and procedures.

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PAYMENT FOR SERVICES--Payment for Self-Directed Personal Assistance Services is contingent on the following factors:

1. The consumer is eligible for Medicaid on the days services are rendered;

2. The provider is eligible for Medicaid participation on the days service is rendered and has agreed to accept the consumer and bill Medicaid;

3. The service is covered by Medicaid;

4. The consumer has received authorization by the Mountain Pacific Quality Health Foundation or is appropriate for high risk services and services are delivered within an authorized span. If services were provided without Authorized Span Recovery will take place;

5. A third party source has not already paid in full for the service;

6. Services are prescribed in the consumer's plan of care;

7. A clean claim is received by ACS within 365 days of the dates of service; and

8. Payment is not available for any days a consumer is hospitalized or in a nursing facility. (Payment is available on the date of admission and the date of discharge.)

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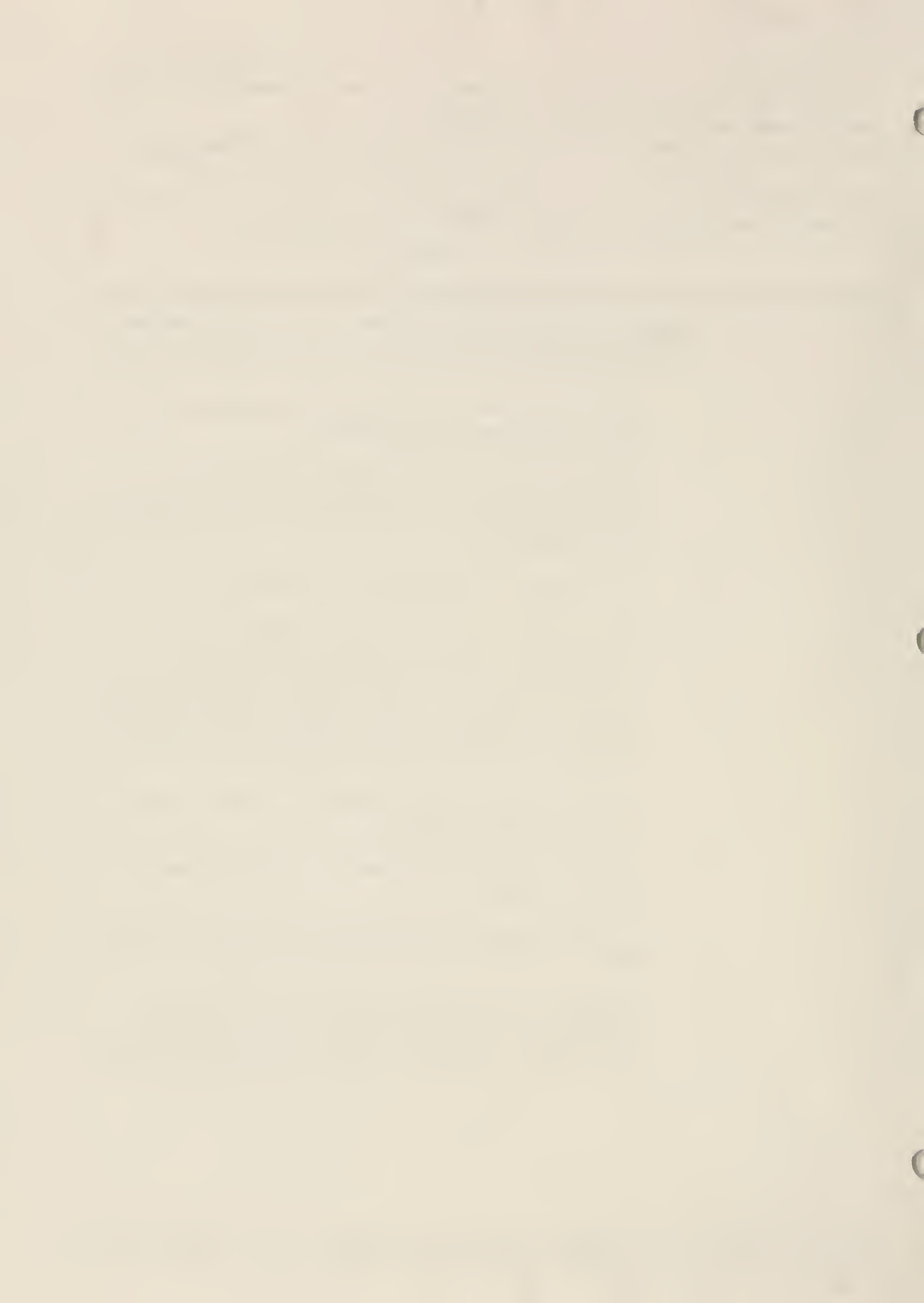

SUBJECT:

Payment Processing

PROCEDURES--The Department contracts with a fiscal intermediary to process all Medicaid claims. The fiscal intermediary is ACS, Inc. Claims are submitted on a CMS1500 claim form or an electronic version. A claim form must be submitted for each consumer. Claim forms must be purchased by the provider agency.

For specific information relating to claims processing, the contract agency should refer to ACS's Personal Assistance Services Provider Manual.

ACS can be contacted by calling or writing:

Montana Medicaid
ACS, Inc.
P.O. Box 8000
Helena, MT 59604
Local: 406-442-1837
In-State Toll-Free: 1-800-624-3958

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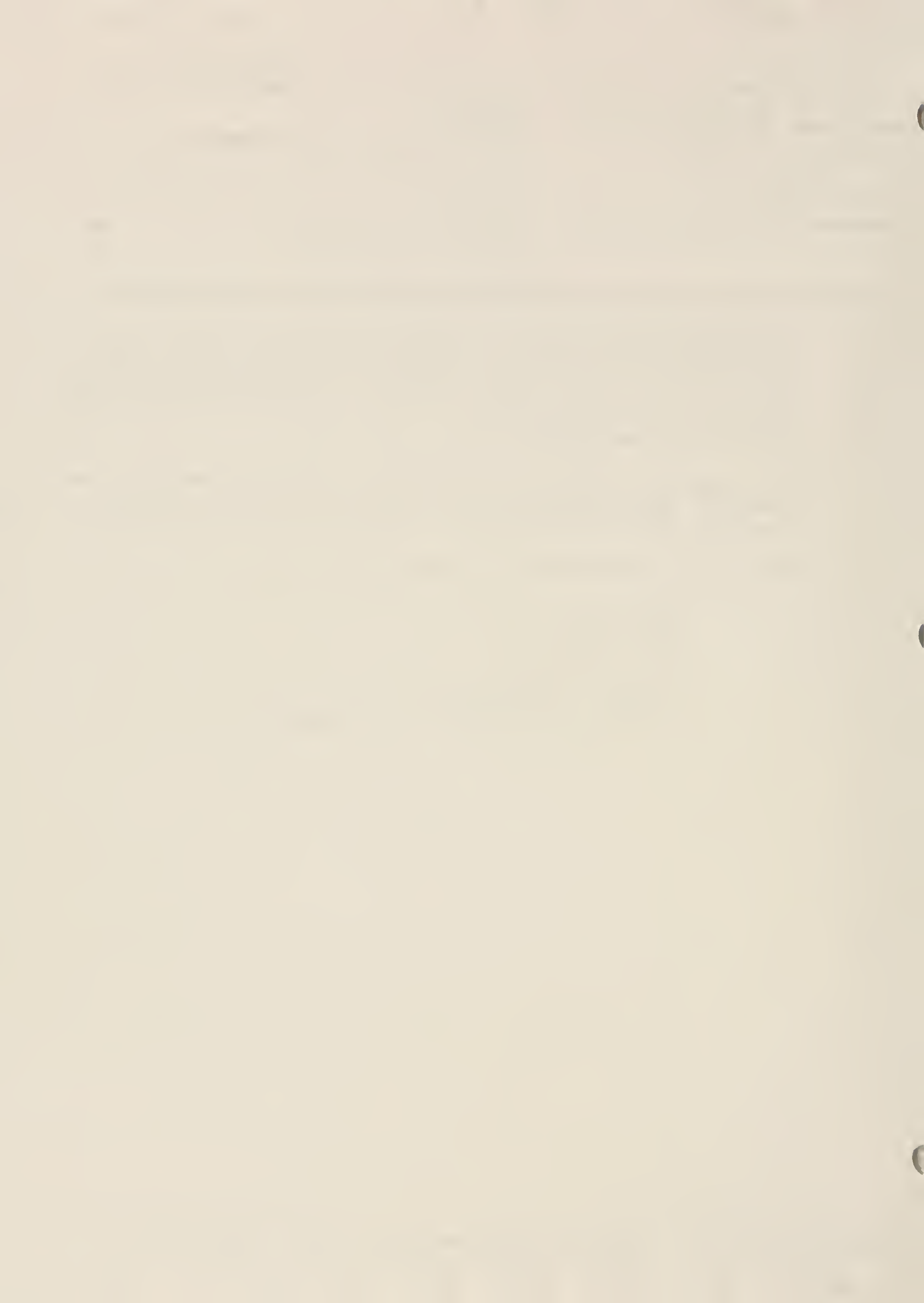

REIMBURSEMENT: Payment to the provider agency is based on a unit rate for personal assistance services set by the Department. Personal assistance services means services provided by a personal assistant or the provider agency for the purposes of program oversight.

PERSONAL ASSISTANT UNIT: A unit of personal assistant service is one 15 minute unit and means an on-site visit specific to a consumer.

OVERSIGHT UNIT: An oversight unit is a 15 minute unit and means an on-site visit specific to a consumer and related activity specific to that consumer. Related activity includes but is not limited to intake/recertification, charting, incident reporting or any similar activity that can be specially assigned to a consumer. Claims for service must be supported by appropriate documentation.

MILEAGE: Mileage may only be billed in conjunction with authorized escort or shopping services. Odometer readings to track mileage and documentation of destination are required to support claims for reimbursement.

TRAVEL TIME (PORTAL TO PORTAL): Reimbursement for travel time is an administrative expense and has already been calculated in the unit rate. Travel time is time spent in travel by a personal assistant as part of her principal activity, such as travel time between consumer home visits. Travel time does not include travel time from the personal assistant's home to the first consumer home visit or from the last consumer home visit back to the personal assistant's home.

NOTE: Travel time is **NOT** to be billed as personal assistant units to the Department.

For more information regarding Portal to Portal, contact the Department of Labor.

PROCEDURE CODES AND RATES:

Procedure codes are established by the Department and are used by the provider agency to bill for services provided. The Department sets the upper limit for allowable rates which are shown below. Some agencies have a lower rate allowed by the Department based on the wage initiative. An agency may not bill a rate higher than the Department approved rate for the agency.

MODIFIERS: TE - A claim for oversight must include a TE modifier to identify the service was oversight and not attendant services.

TS - If a provider receives a timesheet from an employee for dates of services already paid, a claim may be submitted with a TS modifier instead of adjusting the original claim. This is to be used only when increasing units and charges. The TS modifier cannot be used to bill more units and charges for oversight.

UA - Claims submitted for home and community based services must include a UA modifier. Oversight is recorded with both UA and TE modifiers. The UA must be the first modifier followed with the TE.

Claims billed with the TE and TS modifiers will be pended until ACS can verify the service is authorized.

Procedure Code	Service	Unit	Rate
T1019 Modifier U9	Self-Directed PAS-State Plan with approved FY2002 wage initiative plan	15 min	3.16
	Self-Directed PAS-State Plan without approved plan		3.05
Modifier U9 TS	Used to bill additional units and charges after provider has previously been paid for same dates of service.		
T1019	Self-Directed Oversight-State Plan with approved FY2002 wage initiative plan	15 min	3.16
Modifiers U9 TE	Self-Directed Oversight-State Plan without approved plan		3.05
A0080	Medical Transportation for escort and shopping	mile	.13

For HCBS personal assistance services that have been prior authorized by a case management team, the provider agency must have a prior authorization number in order to receive reimbursement.

Procedure Code	Service	Unit	Rate
T1019	HCBS-PAS with approved FY2002	15 min	3.16

Modifier UA	wage initiative plan HCBS-PAS without approved plan		3.05
Modifier UA TS	Used to bill additional units and charges after provider has previously been paid for same dates of service.		
T1019	HCBS-Nurse Supervision (oversight) with approved FY2002 wage initiative plan	15 min	3.16
Modifiers UA TE	HCBS-Nurse Supervision (oversight) without approved plan		3.05
S0215 Modifier UA	HCBS-Social Transportation	Mile	.13

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SUBJECT: Provider Disenrollment Reduction in Service Area

Should a provider decide to discontinue providing self-directed personal assistance services, the provider shall:

1. Provide all current consumers 30 days written notice of the intent to discontinue services.

2. Provide the Personal Assistance Program Manager of the Department with a copy of the written notice and a list of affected consumers.

3. Continue to provide services through the notice period or until all consumers are receiving services through another agency.

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RECORDS--The provider agency must maintain the following records for each consumer:

1. Consumer Overview/Referral Form (DPHHS-SLTC-154);
2. Consumer Profile (DPHHS-SLTC-155);
3. Self-Directed Personal Assistance Services Health Care Professional Authorization (DPHHS-SLTC-160);
4. Self-Directed Personal Assistance Services Consumer Agreement (DPHHS-SLTC-159);
5. Self-Directed Personal Assistance Services Personal Representative Agreement (DPHHS-SLTC-166);
6. Service Delivery Records. A record establishing time spent in a consumer's home and the tasks accomplished. The provider agency is responsible for this form;
7. Records of Oversight visits (DPHHS-SLTC-164). Records must include dates of the visits, the nature of the visit, and any changes in the consumer's service plan;
8. Agency Discharge (DPHHS-SLTC-158);
9. Copies of all submitted CMS 1500 claim forms or appropriate electronic tapes;
10. Records of termination or closures; and
11. Any additional records which provide supporting documentation for reimbursement purposes.

The provider agency must document the following on these records:

1. Services were delivered consistently with program requirements;

2. The amount of services provided to the consumer; and

3. When services were delivered.

The provider agency must keep medical and financial records, supporting documents, and all other records supporting services provided under this program. The provider agency must retain records for a period of at least 6 years and 3 months from date of service. If any litigation, claim or audit is started before the expiration of the retention period provided by the Department, records must be retained until all litigation, claims or audit findings have been resolved.

Upon request, the provider agency must make records available for use by the following:

1. The State of Montana;

2. The Department of Public Health and Human Services (including the adult protective services program);

3. The U.S. Department of Health & Human Services;

4. The U.S. Comptroller General; and

5. The consumer or their legal representative.

When requested, the provider agency must complete and submit audited financial statements and/or cost reports according to Department procedures.

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Department of Public Health and Human Services	SECTION: ELIGIBILITY
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Dually Enrolled Providers

Providers of Self-Directed Personal Assistance Services who also are enrolled providers for regular (or agency based) Personal Assistance Services must maintain separateness.

Separate records of services must be maintained when a consumer exits one program and enters the other; the provider must close one chart and open another. Records for the two services should not be commingled.

Consumers can not participate in both programs at the same time.

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SUBJECT: Consumer Capacity

The Foundation during an authorization visit will determine whether or not a consumer/personal representative is an appropriate candidate for the Self-Directed Personal Assistance (SDPAS) program.

The Foundation will utilize the capacity addendum to record this process. During this process, if the consumer is utilizing a personal representative, they must be present and the PR is screened for capacity using the addendum.. Personal assistants will not be allowed to participate in this process.

If the consumer is deemed capable, the Foundation will proceed with the authorization. Consumers who are found incapable can file for a fair hearing (Refer to SDPAS 302).

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Department of Public Health and Human Services

SELF-DIRECTED

PERSONAL ASSISTANCE SERVICES

SECTION:

SERVICE REQUIREMENTS

SUBJECT:

Program Oversight

The provider agency must review with the consumer the following items before the initiation of services and at the time of recertification:

1. Educate the consumer regarding Department policies, and program parameters and philosophy.

2. Educate the consumer/PR regarding provider agency hiring policies, consumer assistance, personal assistant management training, agency responsibilities, consumer/PR responsibilities and agency complaint procedure.

3. Ensure that additional information and short-term objectives are related to the tasks and report information as to what outcome the consumer/PR hopes to achieve through services authorized on the consumer profile. The objectives should be those of the consumer's and stated in the consumer's own words.

4. Make sure the Health Care Professional Authorization (DPHHS-SLTC-160)is signed by a physician or a health care professional prior to the initiation of services, on an annual basis or in the event there is an addition or deletion of a health maintenance activity.

5. Review with the consumer/PR their responsibilities as outlined in SDPAS 913 and (DPHHS-SLTC 159.

The provider agency must review all service delivery records approved by the consumer. The personal assistant shall only be paid for the hours and tasks authorized by the consumer profile and actually delivered. Service delivery records that are in question should be returned to the consumer for correction or an explanation.

Persons employed as SDPAS program managers are required to participate in Department training.

Claims for services beyond the limit established by the profile are subject to recovery by the department.

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RECERTIFICATION:

An agency representative must make an in-home visit at least once every 180 days to complete the following with the consumer:

1. Review the Consumer Overview/Referral (DPHHS-SLTC-154) and Profile (DPHHS-SLTC-155).;

2. Review functional limitations and need for continued services;

3. Evaluate the consumer's perception of the quality of services provided by the personal assistant;

4. Discuss any changes in program policy which may affect the consumer; and

5. Notify the Foundation, if a need for authorization adjustment based on medical necessity/functional impairment is identified, via the Oversight Documentation form (DPHHS-SLTC-164). Include the Temporary Authorization (DPHHS-SLTC-161) detailing additional services that have been implemented.

The visit may occur at anytime during the month the 180th day falls or when significant changes in condition occur. The provider agency should assist the consumer in tracking these visits. If the visits do not occur as required, a payback can be ordered by the department.

Examples of timing: Admit 1/07/02, oversight visit completed by 7/30/02, admit 1/07/02, oversight for change in condition made on 3/13/02 next oversight visit due by 9/30/02.

The agency must document all supervisory home visits via the Oversight Documentation form (DPHHS-SLTC-164). The agency must include topics discussed and plans for remedying any deficiencies.

ANNUAL REVIEW:

The agency and consumer must meet all requirements of a recertification visit and complete a new Health Care Professional Authorization form (DPHHS-SLTC-160), including the health care professional's signature. The HCP authorization form must be completed by the end of the month the annual review the annual review occurs in. If the current HCP authorization form is not in place recovery **WILL** occur. Complete the plan with the most current information available.

The annual visit by the provider does not have to correspond with the annual visit by the Foundation. Complete the annual paperwork within the month it is due utilizing the most current authorization for services.

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<u>COMPLAINT PROCEDURES</u>--The provider agency must respond to all complaints in a reasonable and prompt manner. The provider agency must maintain records which identify the complaint, the date received and the response.

The provider agency must investigate and respond in writing to all written complaints within ten calendar days of receipt.

At the intake of the consumer's service needs, the agency representative must provide the consumer with a written copy and an explanation of the complaint procedures.

All provider-consumer issues must be addressed in this manner.

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Department of Public Health and Human Services	SECTION: SERVICE REQUIREMENTS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Termination of Services/ Discharges/Temporary Absences

DEPARTMENT TERMINATION--The Department may terminate or reduce self-directed personal assistance services when funding for services is unavailable.

PROGRAM TERMINATION--Consumer participation in the program terminates when: (Reference ARM 37.40.1102). The following is not a comprehensive list of reasons to terminate services.

1. The consumer's health care professional revokes their approval;
2. The consumer no longer has a medical need for services;
3. The consumer demonstrates they are unable to successfully manage within this program;
4. The consumer requests services to terminate; or
5. The consumer fails to participate in the annual review by the Foundation.

The Foundation will send a Personal Assistance Services Authorization form DPHHS-SLTC-152 (Refer to PAS 505) in these instances indicating termination from the program. **A consumer may appeal these decisions using the Department's fair hearing process as outlined on the reverse side of the form.** For these terminations, a provider does not need to submit a discharge notice to the Foundation.

PROVIDER TERMINATION--The provider agency may discharge a consumer for other reasons. This is an action of the provider not the Department. When doing this, the provider agency must provide advance written notice to the consumer based on provider established policy. An Agency Discharge Sheet must be submitted to the Foundation (DPHHS-SLTC-158).

When the discharge is the act of the provider, the consumer does not have access to the Department's fair hearing process. The provider's grievance procedure can be used.

In all cases, the provider agency should make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers, e.g., home health agency, other personal assistance providers, health department, physician, etc.

TEMPORARY ABSENCES—A consumer who is temporarily absent from their home, needs to be discharged for the purposes of program management. An Agency Discharge Sheet (DPHHS-SLTC-158) needs to be submitted to the Foundation when:

1. The consumer is hospitalized or placed in a nursing facility for a period of 30 days or more;

2. The consumer has an extended absence from Montana longer than 30 days and did not utilize Montana self-directed personal assistance services while out of state;

3. For other reasons a 30 day break in service has occurred; and

4. An initial profile has not been activated and is older than 30 days.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: SERVICE REQUIREMENTS SUBJECT: Training

REQUIREMENT: Each consumer participating in self-directed personal assistance services shall establish the training requirements for their individual personal assistants. Consumers should consider basic training, periodic and continuing in-service training, on-the-job instruction and supervision when establishing requirements.

ON-THE-JOB TRAINING: On-the-job training shall be provided by the consumer as needed, to instruct the personal assistant providing personal assistance services in a specific skill or technique or to assist the personal assistant in resolving problems. The consumer may document in notes each personal assistant's ability to function competently and safely and for providing or arranging for necessary additional job training.

The provider agency is not responsible for training personal assistants.

In cases where an experienced attendant is asked to train a new attendant, the consumer is still responsible for the outcome of the training. The consumer should remain involved in order to insure the competency level of the attendants.

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MILEAGE: The personal assistance program will reimburse for mileage under the following circumstances when shopping is authorized:

1. To obtain groceries and health related items; or

2. To obtain pharmaceuticals.

Groceries and health related items should be obtained in an efficient manner by utilizing local resources. A consumer should shop on a weekly or less frequent basis. It is not appropriate to travel excessive distances to obtain groceries.

The personal assistance program will also reimburse for mileage when escort is authorized to receive Medicaid reimbursable medical services **within** the community the consumer resides.

For purposes of the personal assistance program, within the community is defined as up to 20 miles per one-way trip or up to 40 miles per round trip. Reimbursement will be made for the distance to the site of services nearest to the consumer's location. Verification of medical services will be included in the quality assurance process. Documentation of mileage includes client, attendant, odometer readings and destinations (descriptive, not just MD appointment) name of health care professional, store, etc. and purpose of service.

Mileage **outside** the consumer's community must be obtained through the Medicaid state plan transportation program.

TRANSPORTATION:

The Medicaid state plan transportation program reviews travel requests to assure they are for Medicaid covered services. Reimbursement is provided **after** the appointment has been kept and payment is made for the distance to the

site of services nearest to the consumer's location. It is the consumer's choice to utilize a different service site, but transportation reimbursement does not change.

Personal vehicle mileage for medical services outside the consumer's community must be prior authorized by the Mountain Pacific Quality Health Foundation through the Medicaid transportation program. This program can be accessed by calling 1-800-292-7114. Either the agency or the consumer can call. To have services authorized you must provide the Medicaid ID number of the consumer, the date, time and location of the appointment, and to whom the mileage check should be issued.

DO NOT HAVE CHECKS WRITTEN TO YOUR AGENCY.

If you are unclear whether the trip is within or outside the community, contact the transportation center.

If the Medicaid transportation program limits the number of miles for the trip to a closer destination, the personal assistance program will not authorize the difference.

If the Medicaid transportation program denies transportation, the personal assistance program will not authorize the trip. If the consumer disagrees with the denial they may appeal this decision. Appeals are sent in writing to Mountain Pacific Quality Health Foundation, Transportation Program, PO Box 6488, Helena MT 59604.

ESCORT: Medical escort services are authorized when the consumer requires assistance en route or at the destination when a family member or informal caregiver is unable to accompany them except for responsible parties of minor children. It is a separate service from mileage. The personal assistance program will continue to reimburse for the attendant time required for medical escort services regardless of which program is reimbursing for the mileage portion. Escort time is above and beyond time authorized on the profile. The escort line will indicate whether escort is approved or not.

The Department reserves the right to review claims for escort against medical claims to insure the consumer kept the appointment. If the consumer did not attend the appointment, the escort time and mileage is recoverable. The consumer can be discharged from the program if this occurs. Encourage consumers to use this service appropriately.

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Department of Public Health and Human Services	SECTION: SERVICE REQUIREMENTS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Reporting of Serious Occurrences

The provider agency must provide the Regional Program Officer (RPO) with written notification (DPHHS-MA-129)or an agency specific form of:

1. serious occurrences;
2. incidents that involve consumers; or
3. incidents that effect the provider agency's ability to deliver services.

Notification must occur within ten working days. The provider agency must document cause and effect of the incident and an action plan to correct or prevent incidents from occurring in the future. The RPO is responsible for insuring an appropriate response by the provider agency.

Serious occurrences involving either the attendant or consumer may include:

1. Suspected physical or verbal abuse (Refer to SDPAS 309);
2. Neglect of the consumer;
3. Sexual harassment;
4. Injuries requiring medical intervention;
5. An unsafe working environment; and
6. Any event which is reported to Adult Protective Services or law enforcement.

In addition, the provider agency staff must complete quarterly the Serious Occurrences Report (DPHHS-MA-162) and provide a copy for the Department to review. (Refer to SDPAS 909.)

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Department of Public Health and Human Services	SECTION: SERVICE REQUIREMENTS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Home and Community Based Services Program

INTRODUCTION: Some individuals applying for or receiving personal assistance services may also be eligible for the Home and Community Based Services (HCBS) Program.

ELIGIBILITY: To be eligible for the Home and Community Based Services Program, individuals must be Medicaid eligible, require the level of care of a nursing facility, and be physically disabled or over 65 years of age. An individual's total HCBS plan of care costs may not exceed a cost limit set by the Department.

SERVICE DELIVERY: Home and Community Based Services are individually prescribed and arranged according to the individual needs of the consumer. The Department contracts with case management teams to develop an individual plan of care in conjunction with the consumer and attending physician. Refer to SDPAS 806 for a directory of case management teams.

COVERED SERVICES: Services as defined and provided under the HCBS Program are not available under the regular Medicaid program.

Personal assistance services under the HCBS program can include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, specially trained attendants for consumers with extensive needs, or standard personal assistance services which continually exceed State Plan limit. These specific personal assistance services may be self-directed by the consumer, other services under HCBS cannot be self-directed. A self-directed agency may elect to provide other services as

respite or homemaker, but the agency must manage the employee.

CASE MANAGEMENT TEAM'S RELATIONSHIP TO PERSONAL ASSISTANCE PROVIDER AGENCY: It is the case management team's responsibility to develop and monitor home and community based service plans of care for all consumers enrolled in the HCBS Program. The HCBS plan of care does not include personal assistance services as defined and offered under the State Plan Program. It does, however, include HCBS personal assistance, such as socialization and supervision. It is appropriate to share the State Plan personal assistance services plan with the case management team to ensure continuity and coordination of all services

HCBS REFERRAL PROCEDURE: A case management team (CMT) may make a referral to a self-directed personal assistance provider to provide services such as socialization, supervision, specially trained attendants, homemaker, or respite care. The CMT is responsible for providing a written order for services to the SDPAS provider. The provider implements these services based on the order and at the wishes of the consumer. The CMT must notify the provider in writing when the order for services is amended or terminated. The CMT will complete this task using their forms and processes. Providers who have concerns about the process should discuss this with the ordering CMT.

SERVICE AUTHORIZATION: The CMT authorizes HCBS personal assistance services using their form. Authorization for HCBS personal assistance does not require any action by the Mountain Pacific Quality Health Foundation.

EMERGENCY REFERRALS: If the case management team contacts the SDPAS provider agency with an emergency referral, the

SDPAS provider agency will coordinate with the consumer and the case management team to implement services as soon as possible. Emergency requests will be limited to consumers who are at immediate risk of institutionalization or in a hazardous home situation.

REASSESSMENTS: The case management team will keep the SDPAS provider agency informed of all changes affecting the consumer's need for HCBS related personal assistance.

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Department of Public Health and Human Services	SECTION: SERVICE REQUIREMENTS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Live-in Attendants, Family and Significant Others

The self-directed personal assistance program is designed to provide support to caregivers, but not replace them entirely. When a consumer resides with family members (including significant others) or their attendant, it is expected that they will provide the majority of household support tasks, including shopping for groceries.

Tasks which are performed as a function of the home, will not be authorized as personal assistance tasks. Meal prep shall be limited to those meals when the significant party is not available or when the consumer's special diet requires preparation that is different and separate from the household. Household tasks are limited to the consumer's area and clean up after personal assistance tasks. Shopping for groceries is not permissible, but picking up DME or pharmaceuticals may be allowed when it is not convenient for the family to do in conjunction with any household shopping.

This policy applies to all individuals participating in the program. (Refer to SDPAS 403.)

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Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES

SECTION: SERVICE REQUIREMENTS

SUBJECT: Medicare Home Health Aides

At times a consumer may be receiving home health aide services under the Medi**care** benefit and still require Medic**aid** personal assistance services to fulfill their needs. Under the Medi**care** home health benefit, home health aides are limited in their abilities to provide supportive tasks such as escort, shopping, meal prep, household tasks. Both programs can and are able to serve the same consumer. This is an acceptable situation so long as the following occurs:

1. The Medi**care** certified home health agency provides a home health aide based upon their assessment and program limitations, prior to the evaluation of personal assistance services. Medi**care** must pay for services first.

2. The Medic**aid** personal assistance provider does not duplicate the service, but rather provides supplemental services to the consumer. As the payor of last resort, Medic**aid** would not cover those services provided or available under the Medi**care** benefit.

Provider agencies should work closely with the home health agency when this situation arises.

This policy applies to new admissions to the personal assistance program. When a consumer is already receiving personal assistance and becomes eligible for a Medicare home health aide, it is permissible to continue to provide personal assistance services to maintain continuity of care.

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SUBJECT:

Services to Individuals Under Age 21

The personal assistance program is available to consumers under the age of 21*, given the following conditions:

1. Services are authorized based on age appropriateness. This should be measured by determining if in the absence of the disability the individual could perform the tasks. For example, all toddlers require assistance with bathing. Older children, however, could bathe themselves in the absence of their disability.

2. Services are not authorized to support the family home. Meal preparation is limited to those times when a family member is not available to provide the service. Household tasks are limited to cleanup after personal assistance and the child's personal space. Laundry, escort, and shopping are not available.

3. Older consumers (18 to 20) who reside on their own are not subject to this policy.

4. Personal assistance services are not available for the purpose of daycare, respite, supervision, or babysitting.

5. Minor children (under 18) require a personal representative to participate in the program.

* This is the federal Medicaid definition of a child for the purpose of service authorization.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** SERVICE REQUIREMENTS
	SUBJECT: Services to the Developmentally Disabled

Self-Directed Personal Assistance Services are available to those individuals with a developmental disability. A personal representative may be required. However, the services must fit the scope of the Personal Assistance Services Program. Services are not to be authorized or provided for the purpose of providing supervision, habilitation training, or check-in services.

State plan will not reimburse for supervision, respite, habilitation training or check-in services. Consumers who require these types of services should be referred to Developmentally Disabled Program.

No duplication of payment or services is allowed.

Time waiting for the next service provider to show up is not billable. Developmental disability providers need to be made aware of this policy.

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Department of Public Health and Human Services	SECTION: SERVICE REQUIREMENTS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Services to Pregnant Women

Pregnant women are not considered in need of personal assistance services based upon their pregnant state. However, there are instances where complications arise and women are ordered to bed rest. When it poses eminent danger to the mother or unborn child to perform activities of daily living, services may be authorized. These women should also be referred to Targeted Case Management for High Risk Pregnant Women.

If the condition passes or delivery is completed, the personal assistance agency must terminate services.

Services provided to care for the mother's young children while she remains on bed rest is not a benefit of the Self-Directed Personal Assistance Services program. Targeted Case Management can address these issues.

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** SERVICE REQUIREMENTS **SUBJECT:** Personal Representative

Self-directed personal assistance services are available to a cognitively impaired individual, individuals under 18, and individuals under guardianship only when that individual has a qualified personal representative. A personal representative must be an individual who understands the care needs of the consumer, has a personal relationship with the consumer, and is willing and able to fulfill the responsibilities outlined in the Self-Directed Personal Assistance Personal Representative Agreement (DPHHS-SLTC-166).

The personal representative is required to direct the day to day care of the consumer; hire, fire, manage and train all attendants; and manage all paperwork functions. The personal representative must be immediately available to provide or obtain back up services in case of an emergency or when an attendant does not show. Additionally, the personal representative assumes all medical and related liability associated with directing the consumer's care.

If the individual is under guardianship, the appointed guardian should act as the personal representative. If not, the guardian must appoint another individual to assume this role. If the individual is under 18, the personal representative should be a parent or another legally responsible family member. If a personal representative determines they are unable to fulfill their role, a new personal representative must be appointed, or the consumer must be discharged from the program.

A personal representative is not eligible to receive reimbursement for this activity or for the provision of personal assistance services to the consumer they represent. A personal representative may act as a personal assistance attendant to another consumer.

A personal representative must sign the Self-Directed Personal Assistance Services Personal Representative Agreement (DPHHS-SLTC-166) prior to the initiation of services. Failure to abide by this agreement can lead to termination from the program.

If a new personal representative is obtained at anytime, a new DPHHS-SLTC-166 needs to be signed. Any change in personal representatives must be reported to the Foundation. All representatives must be evaluated for capacity. When a personal representative temporarily leaves the area, they are responsible for appointing someone to temporarily manage the consumer's care. A temporary personal representative does not need to sign this statement, however, the agency needs to be notified of the temporary change.

All personal representatives must receive orientation to the program, just as a consumer would. Due to the nature of this role, it is not appropriate for a consumer's care manager or an employee of the provider agency to act as a personal representative.

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Department of Public Health and Human Services	**SECTION:** DIRECTORIES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SUBJECT:** Division Organization Chart

Following is the organization chart of the Senior and Long Term Care Division.

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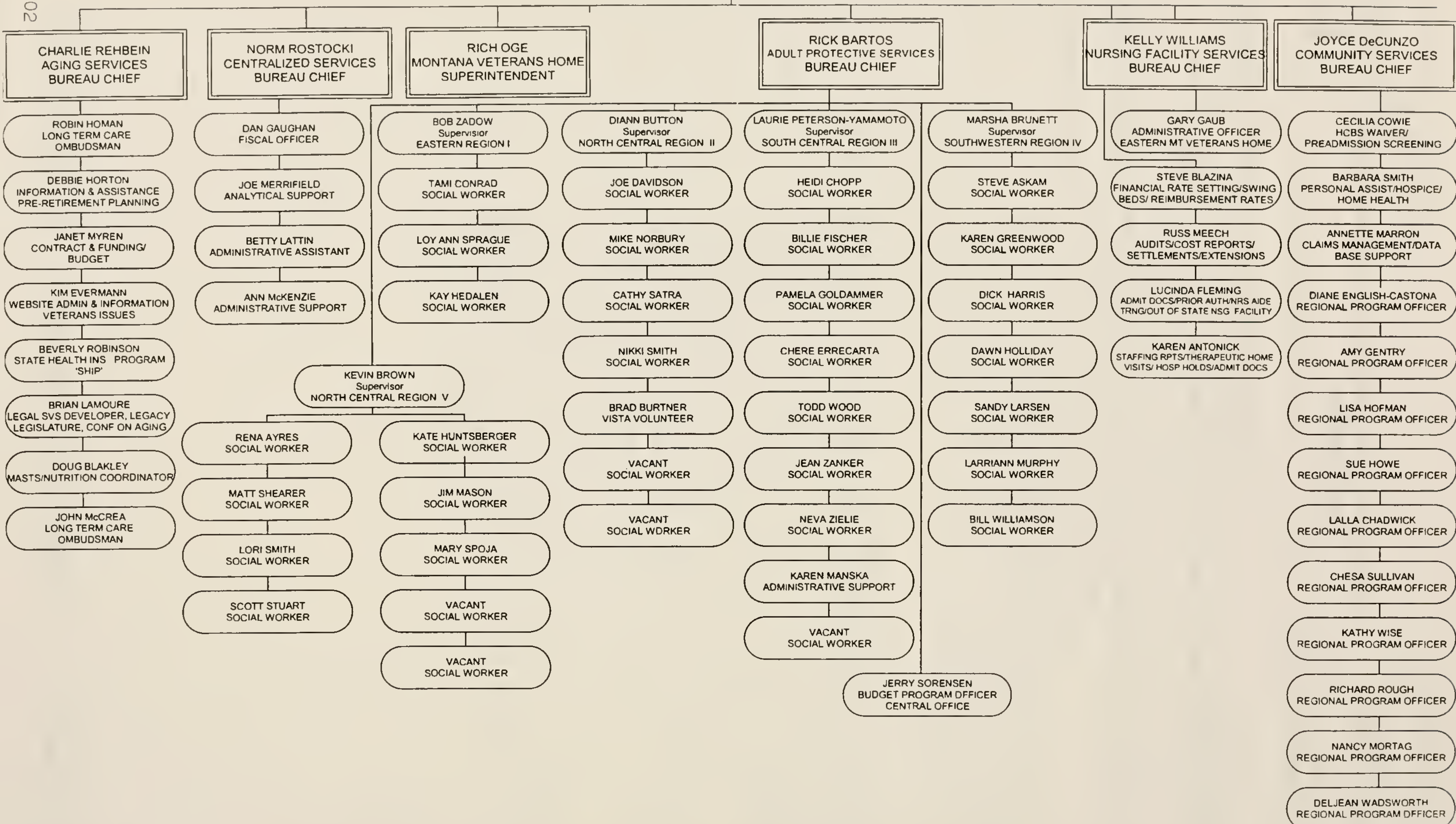
MIKE HANSHEW, Administrator
SENIOR AND LONG TERM CARE DIVISION
CHARLIE REHBEIN
AGING SERVICES
BUREAU CHIEF
ROBIN HOMAN
LONG TERM CARE
OMBUDSMAN
DEBBIE HORTON
INFORMATION & ASSISTANCE
PRE-RETIREMENT PLANNING
JANET MYREN
CONTRACT & FUNDING/
BUDGET
KIM EVERMANN
WEBSITE ADMIN & INFORMATION
VETERANS ISSUES
BEVERLY ROBINSON
STATE HEALTH INS PROGRAM
'SHIP'
BRIAN LAMOURE
LEGAL SVS DEVELOPER, LEGACY
LEGISLATURE, CONF ON AGING
DOUG BLAKLEY
MASTS/NUTRITION COORDINATOR
JOHN McCREA
LONG TERM CARE
OMBUDSMAN
NORM ROSTOCKI
CENTRALIZED SERVICES
BUREAU CHIEF
DAN GAUGHAN
FISCAL OFFICER
JOE MERRIFIELD
ANALYTICAL SUPPORT
BETTY LATTIN
ADMINISTRATIVE ASSISTANT
ANN McKENZIE
ADMINISTRATIVE SUPPORT
RICH OGE
MONTANA VETERANS HOME
SUPERINTENDENT
BOB ZADOW
Supervisor
EASTERN REGION I
TAMI CONRAD
SOCIAL WORKER
LOY ANN SPRAGUE
SOCIAL WORKER
KAY HEDALEN
SOCIAL WORKER
KEVIN BROWN
Supervisor
NORTH CENTRAL REGION V
RENA AYRES
SOCIAL WORKER
MATT SHEARER
SOCIAL WORKER
LORI SMITH
SOCIAL WORKER
SCOTT STUART
SOCIAL WORKER
KATE HUNTSBERGER
SOCIAL WORKER
JIM MASON
SOCIAL WORKER
MARY SPOJA
SOCIAL WORKER
VACANT
SOCIAL WORKER
VACANT
SOCIAL WORKER
DIANN BUTTON
Supervisor
NORTH CENTRAL REGION II
JOE DAVIDSON
SOCIAL WORKER
MIKE NORBURY
SOCIAL WORKER
CATHY SATRA
SOCIAL WORKER
NIKKI SMITH
SOCIAL WORKER
BRAD BURTNER
VISTA VOLUNTEER
VACANT
SOCIAL WORKER
VACANT
SOCIAL WORKER
RICK BARTOS
ADULT PROTECTIVE SERVICES
BUREAU CHIEF
LAURIE PETERSON-YAMAMOTO
Supervisor
SOUTH CENTRAL REGION III
HEIDI CHOPP
SOCIAL WORKER
BILLIE FISCHER
SOCIAL WORKER
PAMELA GOLDAMMER
SOCIAL WORKER
CHERE ERRECARTA
SOCIAL WORKER
TODD WOOD
SOCIAL WORKER
JEAN ZANKER
SOCIAL WORKER
NEVA ZIELIE
SOCIAL WORKER
KAREN MANSKA
ADMINISTRATIVE SUPPORT
VACANT
SOCIAL WORKER
JERRY SORENSEN
BUDGET PROGRAM OFFICER
CENTRAL OFFICE
MARSHA BRUNETT
Supervisor
SOUTHWESTERN REGION IV
STEVE ASKAM
SOCIAL WORKER
KAREN GREENWOOD
SOCIAL WORKER
DICK HARRIS
SOCIAL WORKER
DAWN HOLLIDAY
SOCIAL WORKER
SANDY LARSEN
SOCIAL WORKER
LARRIANN MURPHY
SOCIAL WORKER
BILL WILLIAMSON
SOCIAL WORKER
KELLY WILLIAMS
NURSING FACILITY SERVICES
BUREAU CHIEF
GARY GAUB
ADMINISTRATIVE OFFICER
EASTERN MT VETERANS HOME
STEVE BLAZINA
FINANCIAL RATE SETTING/SWING
BEDS/ REIMBURSEMENT RATES
RUSS MEECH
AUDITS/COST REPORTS/
SETTLEMENTS/EXTENSIONS
LUCINDA FLEMING
ADMIT DOCS/PRIOR AUTH/NRS AIDE
TRNG/OUT OF STATE NSG FACILITY
KAREN ANTONICK
STAFFING RPTS/THERAPEUTIC HOME
VISITS/ HOSP HOLDS/ADMIT DOCS
JOYCE DeCUNZO
COMMUNITY SERVICES
BUREAU CHIEF
CECILIA COWIE
HCBS WAIVER/
PREADMISSION SCREENING
BARBARA SMITH
PERSONAL ASSIST/HOSPICE/
HOME HEALTH
ANNETTE MARRON
CLAIMS MANAGEMENT/DATA
BASE SUPPORT
DIANE ENGLISH-CASTONA
REGIONAL PROGRAM OFFICER
AMY GENTRY
REGIONAL PROGRAM OFFICER
LISA HOFMAN
REGIONAL PROGRAM OFFICER
SUE HOWE
REGIONAL PROGRAM OFFICER
LALLA CHADWICK
REGIONAL PROGRAM OFFICER
CHESA SULLIVAN
REGIONAL PROGRAM OFFICER
KATHY WISE
REGIONAL PROGRAM OFFICER
RICHARD ROUGH
REGIONAL PROGRAM OFFICER
NANCY MORTAG
REGIONAL PROGRAM OFFICER
DELJEAN WADSWORTH
REGIONAL PROGRAM OFFICER

Community Services Bureau
Senior & Long Term Care Division
P.O. Box 4210
Helena, MT 59604-4210
Fax: 406-444-7743

Vacant, Bureau Chief

Denise King, Program Manager
- Home Health Services
- Personal Assistance Services
- Self-Directed Personal Assistance Services
- Hospice Services, Home Dialysis

Cecilia Cowie/Robin Homan, Program Manager
- Home and Community Based Services
- Preadmission Screening
- Traumatic Brain Injury Planning Grant

Annette Marron, Program Specialist
- Claims Resolution
- State Supplemental Payment Program

Karen Antonick, Program Specialist
- Grant Coordinator
- Montana CHOICE Personal Assistance Grant

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Department of Public Health and Human Services	SECTION: DIRECTORIES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Regional Program Officers

NAME & ADDRESS	PHONE NUMBER	COUNTIES
Kathy Wise Kim Kennedy Senior & Long Term Care Division 2121 Rosebud Dr., Ste D Billings, MT 59102	Phone: 655-7644 655-7635 Fax: 655-7646	Big Horn, Carbon, Golden Valley, Musselshell, Stillwater, Treasure, Wheatland, Yellowstone
Lalla Chadwick Senior & Long Term Care Division 220 W Lamme, Ste 1E Bozeman, MT 59715	Phone: 586-4089 Fax: 587-7863	Gallatin, Madison, Park, Sweetgrass
Chesa Sullivan Senior & Long Term Care Division 700 Casey Butte, MT 59701	Phone: 496-4989 Fax: 782-8728	Beaverhead, Deer Lodge, Granite, Silver Bow, Montana State Prison
Susan Howe Senior & Long Term Care Division 218 West Bell, Suite 205 Glendive, MT 59330	Phone: 377-6252 Fax: 377-1240	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, Wibaux
Nancy Mortag Deljean Wadsworth Senior & Long Term Care Division 201 1st Street South Great Falls, MT 59405	Phone: 453-8902 Phone: 453-8975 Fax: 454-6084	Blaine, Cascade, Choteau, Fergus, Glacier, Hill, Judith Basin, Liberty, Petroleum, Phillips, Pondera, Teton, Toole
Diane English-Castona Senior & Long Term Care Division 3075 N Montana Ave PO Box 202958 Helena, MT 59620-2958	Phone: 444-1707 Fax: 444-9659	Broadwater, Jefferson, Lewis & Clark, Meagher, Powell, Montana State Hospital Long Term Care Unit

NAME & ADDRESS	PHONE NUMBER	COUNTIES
Richard Rough Senior & Long Term Care Division 2282 Hwy 93 S P.O. Box 2357 Kalispell, MT 59903-2357	Phone: 755-5420 Fax: 751-5944	Flathead, Lake, Lincoln
Amy Gentry Dave Gentry Senior & Long Term Care Division 2677 Palmer, Ste 240 Missoula, MT 59808	Phone: 329-1312 329-1310 Fax: 329-1313	Mineral, Missoula, Ravalli, Sanders

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Department of Public Health and Human Services

PERSONAL ASSISTANCE SERVICES

SECTION: DIRECTORIES

SUBJECT: Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Fallon Medical Complex-Home Care Kathleen Lehti 202 S 4th St W P.O. Box 820 Baker, MT 59313	Phone: 778-3331 Fax: 778-3438	Carter, Fallon
Alternative Nursing Services Christina Clark 8523 MT Hwy 35 #C PO Box 1928 Bigfork, MT 59911	Phone: 837-3555 Fax: 837-3551	Flathead, Lake
Intrepid USA Jan Hawley 705 Lincoln Lane Billings, MT 59105	Phone: 245-6356 Fax: 245-1224	Bighorn, Carbon, Musselshell, Stillwater, Treasure, Yellowstone
YCCHD/Private Duty Program Carol Pfau 123 S 27th PO Box 35033 Billings, MT 59107	Phone: 247-3270 Fax: 247-3303	Big Horn, Carbon, Golden Valley, Musselshell, Yellowstone
Chippewa Cree Clinic Kris Martin RR 1664 Box Elder, MT 59521	Phone: 395-4486 Fax: 395-4408	Rocky Boy Reservation

SECTION:	SUBJECT:
DIRECTORIES	Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Home Care Services Rosemarie Jones 321 E Main, Ste 215 PO Box 877 Bozeman, MT 59715 501 East Front St Ste 515 Butte MT 59701	Phone: 582-1680 800-555-3111 Fax: 582-1569	Beaverhead, Big Horn, Broadwater, Carbon, Custer, Daniels, Dawson, Deer Lodge, Gallatin, Golden Valley, Granite, Jefferson, Lake, Lewis & Clark, Madison, McCone, Mineral, Missoula, Musselshell, Park, Phillips, Powder River, Powell, Prairie, Ravalli, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Silver Bow, Stillwater, Sweetgrass, Treasure, Valley, Yellowstone, and Northern Cheyenne Reservation
Intrepid USA Lynn Rugheimer 2411 West Main, Suite 2A Bozeman MT 59718	Phone: 586-0022 Fax: 586-1886	Gallatin, Madison, Park, Sweet Grass
Blackfeet PCA Program Connie Bremner P.O. Box 1070 Browning, MT 59417	Phone: 338-3482 Fax: 338-3480	Blackfeet Indian Reservation, Glacier, Pondera, Toole
Intrepid USA Kathy Galle 700 E Front Street Butte MT 59701	Phone: 723-8933 Fax: 723-4597	Beaverhead, Deer Lodge, Jefferson, Silver Bow
MT Easter Seals Personal Care Program Alberta Lopez 3703 Harrison Butte, MT 59701	Phone: 533-0020 Fax: 533-0019	Deer Lodge, Granite, Jefferson, Powell, Silver Bow

PROVIDER	PHONE NUMBER	COUNTIES
Accessible Space, Inc. Kris Kleinschmidt 1615 Oasis Court Great Falls, MT 59405	Phone: 771-1896 Fax: 771-7008	Southwinds Estates
MT Easter Seals Personal Care Program Naomi Burkett 4400 Central Ave Great Falls, MT 59405	Phone: 771-3777 Fax: 761-5110	Cascade
Spectrum Medical Inc Deana Drew 2526 12th Ave S Great Falls, MT 59405	Phone: 727-9322 800-870-9322 Fax: 727-8327	Cascade, Deer Lodge, Gallatin, Granite, Silver Bow
Caring Hands Home Care Services Bonnie Pratt 825 10th St S Great Falls, MT 59405	Phone: 454-9099 Fax: 454-2950	Blaine, Cascade, Choteau, Glacier, Hill, Pondera, Teton, Toole
Intrepid USA Connie Hix 105 Smelter Ave Ste 110 Great Falls MT 59404	Phone: 761-7800 Fax: 761-5908	Cascade, Choteau, Glacier, Pondera, Toole, Teton
Tribal Health - Fort Belknap Agency Nadine Sullivan RR1 Box 66 Harlem, MT 59526	Phone: 353-3202 Fax: 353-3301	Fort Belknap Reservation
Hill County Area X Agency on Aging Evelyn Havskjold, Director 2 West Second St Havre, MT 59501	Phone: 265-5464 Fax: 265-5487	Blaine, Hill
Intrepid USA Teresa Hall 845 5th Street Havre MT 59501	Phone: 265-4776 Fax: 265-1725	Blaine, Choteau, Hill, Liberty

SECTION:	SUBJECT:
DIRECTORIES	Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
HomeLink of St. Peter's Sheila Cotter 2475 Broadway Helena, MT 59601	Phone: 444-2244 Fax: 447-2723	Jefferson, Lewis & Clark
Intrepid USA Kris Reitz 1300 Aspen, Suite 2 Helena MT 59601	Phone: 443-4140 Fax: 447-3144	Broadwater, Jefferson, Lewis & Clark, Meagher
Personal Touch Home Care Rita Nicholson & Kimberly Audit 214 Main P.O. Box 8300 Kalispell, MT 59904-1300	Phone: 758-5422 Fax: 752-6582	Flathead
Intrepid USA Jason Johnson 1117 S Main St. Kalispell, MT 59901	Phone: 755-4968 Fax: 752-5157	Flathead, Glacier, Lake, Lincoln, Sanders
In Home Personal Care Nancy Berg 629 NE Main Lewistown, MT 59457	Phone: 538-6302 Fax: 538-6306	Fergus, Judith Basin
A Full Life Agency Evelyn Timmons Chris Redifer 108 E 4th St, Ste 103 Libby, MT 59923	Phone: 293-9651 Fax: 293-9706	Lincoln, Mineral, Sanders
Phillips County Hospital Association Sue Davis 417 S 4th St E PO Box 640 Malta MT 59538	Phone: 654-1100 ex 43 Fax: 654-2876	Phillips, Fort Belknap Reservation

PROVIDER	PHONE NUMBER	COUNTIES
A to Z Personnel Agency June Clark Anna Cox 2126 Dixon Missoula, MT 59801	Phone: 721-1020 Fax: 721-1025	Missoula
Nightingale Nursing Loreen Beeman 1903 S Russell Missoula, MT 59801	Phone: 541-1700 800-357-4799 Fax: 541-1703	Missoula, Ravalli
Partners in Home Care Kathy Farrell, RN 2687 Palmer, Ste B Missoula, MT 59808	Phone: 728-8848 Fax: 327-3727	Granite, Missoula
Home Caregivers, Inc. Kathy Skates 407 Second St W PO Box 747 Polson, MT 59860	Phone: 883-3590 Fax: 883-1923	Lake, Lincoln, Sanders
Sidney Health Center Home Health Nancy Dynneson 216 14th Avenue SW Sidney, MT 59270	Phone: 488-2104 Fax: 488-2115	Richland
Intrepid USA Vickie Dore 107 Second St NE Sidney MT 59270	Phone: 433-1157 Fax: 433-4863	Dawson, Richland, Roosevelt
Independent Services Corp Mary Runcorn 1716 N Union Rd Spokane, WA 99206	Phone: 509-921-5914 Fax: 509-921-0527	Spokane

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: DIRECTORIES SUBJECT: Self-Directed Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Home Care/Fallon Medical Complex Kathleen Lehti 202 S. 4th St. W. P.O. Box 820 Baker, MT 59313	Phone: 778-3331 Fax: 778-3438	Carter, Fallon
Alternative Nursing Services Christina Clark 8523 Hwy 35 #C PO Box 1928 Bigfork, MT 59911	Phone: 837-3555 Fax: 837-3551	Flathead, Lake
LIFTT Ursula Brese 914 Wyoming Billings MT 59101	Phone: 259-5181 Fax: 259-5259	Big Horn, Carbon, Carter, Custer, Fallon, Garfield, Golden Valley, McCone, Mussellshell, Powder River, Prairie, Richland, Rosebud, Stillwater, Treasure, Wibaux, Yellowstone
Intrepid USA Jan Hawley 705 Lincoln Lane Billings, MT 59105	Phone: 245-6356 Fax: 245-1224	Bighorn, Carbon, Treasure, Musselshell, Stillwater, Yellowstone
North Central Independent Living Ctr Sharlo LaFountain 1120 25th Ave NE Black Eagle, MT 59414	Phone: 452-9834 Fax: 453-3940	Blaine, Cascade, Chouteau, Daniels, Fergus, Glacier, Hill, Judith Basin, Liberty, Phillips, Pondera, Petroleum, Roosevelt, Sheridan, Teton, Toole, Valley

PROVIDER	PHONE NUMBER	COUNTIES
Intrepid USA Lynn Rugheimer 2411 West Main, Suite 2A Bozeman MT 59718	Phone: 586-0022 Fax: 586-1886	Gallatin, Madison, Park, Sweet Grass
Home Care Montana Rosemarie Jones 321 E Main, Ste 215 PO Box 877 Bozeman, MT 59711	Phone: 582-1680 800-555-3111 Fax: 582-1569	Statewide
Blackfeet PCA Program Connie Bremner P.O. Box 1070 Browning, MT 59417	Phone: 338-3482 Fax: 338-3480	Blackfeet Indian Reservation, Glacier, Pondera, Toole
Intrepid USA Kathy Galle 700 E Front Butte MT 59701	Phone: 723-8933 Fax: 723-4597	Beaverhead, Deer Lodge, Jefferson, Silver Bow
MT Easter Seals Personal Care Program Alberta Lopez 3703 Harrison Butte, MT 59701	Phone: 533-0020 Fax: 533-0019	Beaverhead, Deer Lodge, Gallatin, Granite, Jefferson, Powell, Silver Bow
Caring Hands Home Care Services Bonnie Pratt 825 10th St S Great Falls, MT 59405	Phone: 454-9099 Fax: 454-2950	Cascade
Intrepid USA Connie Hix 105 Smelter Ave Ste 110 Great Falls, MT 59404	Phone: 761-7800 Fax: 761-5908	Cascade, Choteau, Glacier, Pondera, Toole, Teton

SECTION: DIRECTORIES

SUBJECT: Self-Directed Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Spectrum Medical Inc Deana Drew 2526 12th Ave S Great Falls, MT 59405	Phone: 727-9322 800-870-9322 Fax: 771-8327	Beaverhead, Broadwater, Cascade, Choteau, Deer Lodge, Gallatin, Granite, Hill, Lewis & Clark, Liberty, Madison, Pondera, Powell, Silver Bow, Teton, Toole
Intrepid USA Teresa Hall 845 5th Street Havre, MT 59501	Phone: 265-4776 Fax: 265-1725	Blaine, Choteau, Hill, Liberty
Intrepid USA Kris Reitz 1300 Aspen, Suite 2 Helena MT 59601	Phone: 443-4140 Fax: 447-3144	Broadwater, Jefferson, Lewis & Clark, Meagher
MT Independent Living Project Georgia Burns 1130 Butte PO Box 5415 Helena MT 59604	Phone: 442-5755 Fax: 442-1612	Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis & Clark, Madison, Meagher, Park, Powell, Silver Bow, Sweetgrass, Wheatland
Intrepid USA Jason Johnson 1117 S Main St Kalispell, MT 59901	Phone: 755-4968 Fax: 752-5157	Flathead, Glacier, Lake, Lincoln, Sanders
Express Personnel Service Carrie Schaff 3709 Brooks Missoula, MT 59801	Phone: 542-0323 Fax: 543-7288	Flathead, Lake, Mineral, Missoula, Ravalli, Sanders
Consumer Direct Services Bill Woody 1903 S Russell Missoula, MT 59801	Phone: 541-8700 866-438-8591 Fax: 541-8704	Statewide

PROVIDER	PHONE NUMBER	COUNTIES
Partners In Home Care Kathy Farrell 2687 Palmer, Ste B Missoula, MT 59808	Phone: 728-8848 Fax: 327-3688	Granite, Lake, Mineral, Missoula, Ravalli
Summit ILC Mike Mayer Professional Plaza 700 SW Higgins St, 101 Missoula, MT 59803	Phone: 728-1630 Fax: 829-3309	Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, Sanders
Progressive Personal Care Beth Anderson Kelly Reynolds PMB 434 2401 Brooks St 901 SW Higgins Ste 4 Missoula MT 59801	Phone: 251-9333 Fax: 866-772-4622 406-543-6043	Statewide
Home Caregivers Kathy Skates 407 Second St W PO Box 747 Polson, MT 59860	Phone: 883-3590 Fax: 883-1923	Lake, Lincoln, Sanders
Area II Agency on Aging Jean Olson 1502 4th St W PO Box 127 Roundup, MT 59072	Phone: 323-1320 Fax: 323-3859	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone, Crow Indian Reservation, Northern Cheyenne Indian Reservation
Intrepid USA Vickie Dore 107 Second Street NE Sidney MT 59270	Phone: 433-1157 Fax: 433-4863	Dawson, Richland, Roosevelt

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NAME & ADDRESS	STAFF	COUNTIES
Community Medical Center/Rehab HCBS Case Management 607 SW Higgins Missoula, MT 59803 Phone: 327-4585 Fax: 327-4484	Jayne Lux, RN Joann Haven, RN Laura Sherry, RN Sue Kirchmyer, RN Kathy Flynn, SW Tim Laskowski, SW Vickie Robeson, SW Ruby Finch, RN	Mineral, Missoula, Ravalli
Partners in Home Care HCBS Case Management 2687 Palmer, Ste B Missoula, MT 59808 Phone: 728-8848 Fax: 327-3688	Marlene Swisher, RN Ruth Cleveland, SW Susan Allen, SW Mary Jo Diddell, RN	Mineral, Missoula, Ravalli
Yellowstone City-County Health Dept HCBS Case Management 123 S 27th P.O. Box 35033 Billings, MT 59107 Phone: 247-3226 Fax: 247-3202	Ron McKenna, SW Tris Newell, RN Linda Collins,RN Dee Dee Chiesa, SW Jill Egan, SW Kaye Blair, RN	Big Horn, Carbon, Rosebud, Stillwater, Sweetgrass, Treasure, Yellowstone
Easter Seal HCBS Case Management 4400 Central Ave Great Falls, MT 59405 Phone: 761-3680 Fax: 761-5110	Karla Egan, LPN Mickie Anderson, RN Kathy Smith, RN Stu Lekander. SEAS Ruby Howington, SW Michelle Lindgren, SW	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole
District IX HRDC HCBS Case Management 32 S Tracy Bozeman, MT 59715 Phone: 586-3134 Fax: 585-3538	Barb Hilton, RN Charlene Findlay, SW Stacey Nelson, SW	Gallatin, Park, Madison, Meagher

NAME & ADDRESS	STAFF	COUNTIES
L&C City-Co Health Dept HCBS Case Management 1930 9th Ave, Ste 207 Helena, MT 59601 Phone: 443-2584 Fax: 457-8990	Jeanne Underhill, RN Kristi Heilman, RN Dana Gibson, SW Robie Pierson, SW	Broadwater, Jefferson, Lewis and Clark
Holy Rosary Home Care HCBS Case Management 2600 Wilson St #30 Miles City, MT 59301 Phone: 233-3810 Fax: 233-7134	Laurie Ellinghouse, SW Marlys Taylor, RN	Carter, Custer, Dawson, Fallon, Garfield, Powder River, Prairie, Rosebud, Wibaux
Sidney Health Center HCBS Case Management 124 S Central Sidney, MT 59270 Phone: 488-2193 Fax:	Kerry Reitz, SW Laurie Amunrud, RN	Daniels, Dawson, McCone, Richland, Roosevelt, Sheridan, Valley
NW MT Human Resources HCBS Case Management 214 Main St P.O. Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 752-6582	Deb Reimnitz, RN Sue Pratt, SW Marla Elliot, RN Emilianne Lansdown, SW	Flathead, Lake, Lincoln, Sanders
Spectrum Medical, Inc. HCBS Case Management 3475 Monroe, Ave Ste 102 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Georgia Peterson, RN Virginia Mick, RN Staci Berceir, SW Kama Kwiecinski, SW	Beaverhead, Deer Lodge, Granite, Powell, Silver Bow

SECTION:	SUBJECT:
DIRECTORIES	Case Management Teams

NAME & ADDRESS	STAFF	COUNTIES
Central Montana Medical Center HCBS Case Management 408 Wendell Ave Lewistown, MT 59457 Phone: 538-6297 (Kathy) 538-6382 (Tara) Fax: 538-6267	Kathy Hodgeson, RN Tara Taylor, SW	Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Phillips Wheatland
Area II Agency on Aging HCBS Case Management 1504 Fourth Street W Roundup, MT 59072 Phone: 323-1320 Fax: 323-3859	Betty Jo Hiermeier,SW Lindy Soelter, LPN	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Mussellshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone
Western Montana AAA HCBS Case Management 110 Main St Ste 5 Polson, MT 59860 Phone: 883-7284 Fax: 883-7363	John Freemole, SW Vicki Holmberg, RN Grace Shafer, RN	Lake, Lincoln, Mineral Ravalli, Sanders
Area VIII Agency on Aging HCBS Case Management 2526 12th Ave S PO Box 6453 Great Falls, MT 59405 Phone: 727-9322 Fax: 771-8337	Nancy Swenson, SW Erinn Addy, RN	Cascade
Area X Agency on Aging HCBS Case Management 2 W 2nd St Havre, MT 59501 Phone: 265-5464 Fax: 265-3611	Connie LaSalle, RN Lisa Passon, SW	Hill
Area XI Agency on Aging HCBS Case Management 337 Stephens Ave Missoula, MT 59801 Phone: 728-7682 Fax: 728-7687	Elizabeth Yahner Polson 883-7284 John Freemole, SW Vicki Holmberg, RN Grace Shafer, RN	Missoula

NAME & ADDRESS	STAFF	COUNTIES
Area IV Agency on Aging 201 S Main PO Box 1717 Helena, MT 59624 Phone: 447-1680 Fax: 447-1629	Linda Simmons, SW Karen George, RN	Broadwater, Gallatin, Jefferson, Lewis & Clark, Meagher, Park
Area III Agency on Aging 2526 12th Ave S PO Box 6453 Great Falls, MT 59405 Phone: 727-9322 Fax: 771-8337	Nancy Swenson, SW Erinn Addy, RN	Chouteau, Glacier, Liberty, Pondera, Teton, Toole
Area V Agency on Aging 3475 Monroe Ave, Ste 102 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Virginia Mick, RN Staci Berceir, SW	Beaverhead, Deer Lodge, Granite, Madison, Powell, Silver Bow
Area IX Agency on Aging 214 Main St PO Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 752-6582	Marla Elliot, RN Emilianne Lansdown, SW	Flathead

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** DIRECTORIES **SUBJECT:** Mountain Pacific Quality Health Foundation Staff

NAME & ADDRESS	PHONE	LOCATION
Fax Numbers	406-443-8067 800-268-5767	Helena
Paulette Geach, RN **Contract Manager**	406-443-4020 ext 123	Helena
Myrna Seno, Rn **Program Manager**	406-443-4020 ext 129	Helena
Lori Rowe Ericka Alm **Administrative Support**	406-443-4020 ext 130	Helena
Nurse Coordinators Rona Meyer, RN	406-775-6839 800-268-0428	Southeastern Region
Colleen Cooney, RN	406-585-7469 800-268-6193	SouthCentral Region
Linda Birkosky	800-268-2395	North Central
Jennifer Zody, Rn	406-443-4020 ext. 196 800-268-5767	Central Region
Barbra Carvajal, RN	406-273-0641 800-268-7896	Southwestern Region
Mary Danelson, RN	406-783-5541 800-268-3198	Northeastern Region
		North

	800-268-3198	Western

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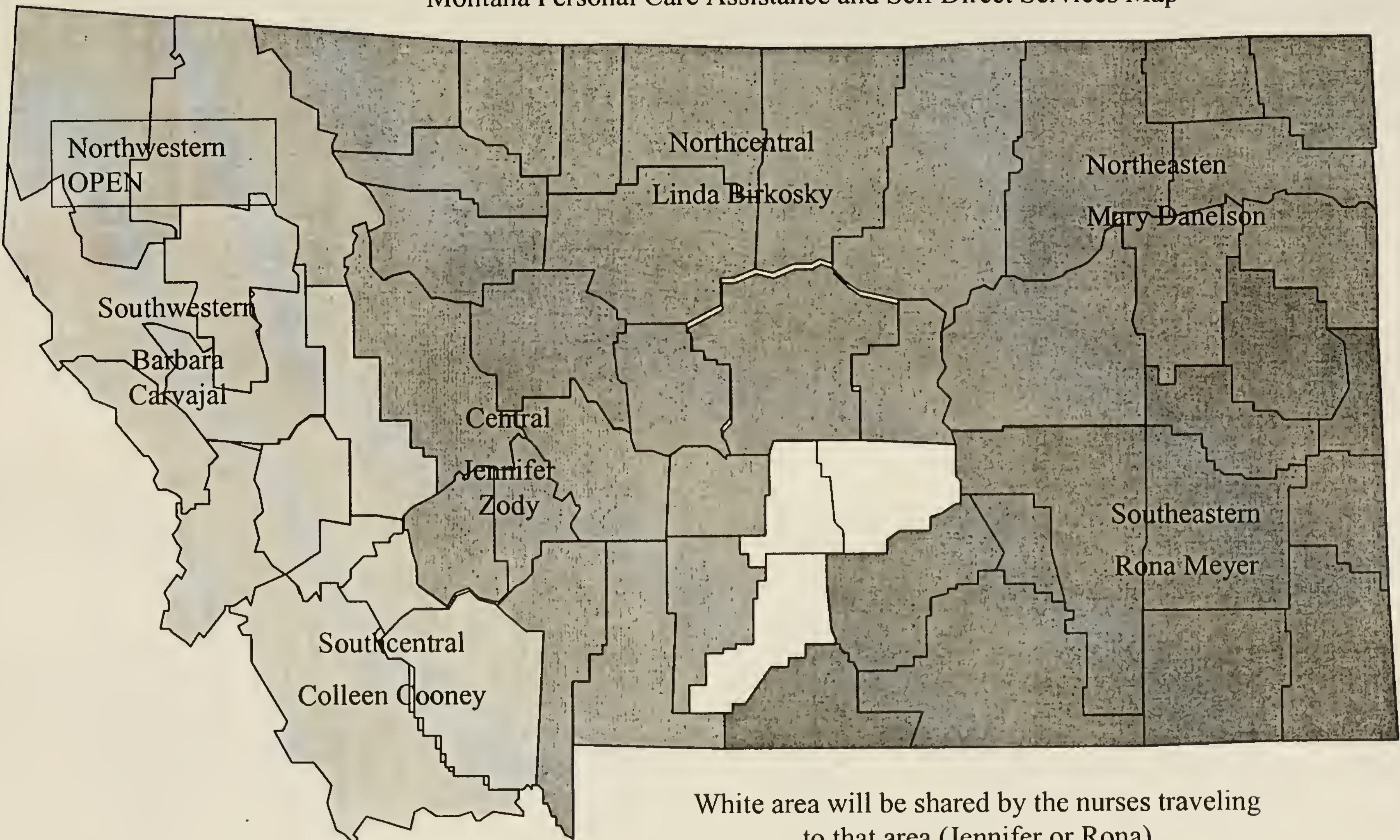
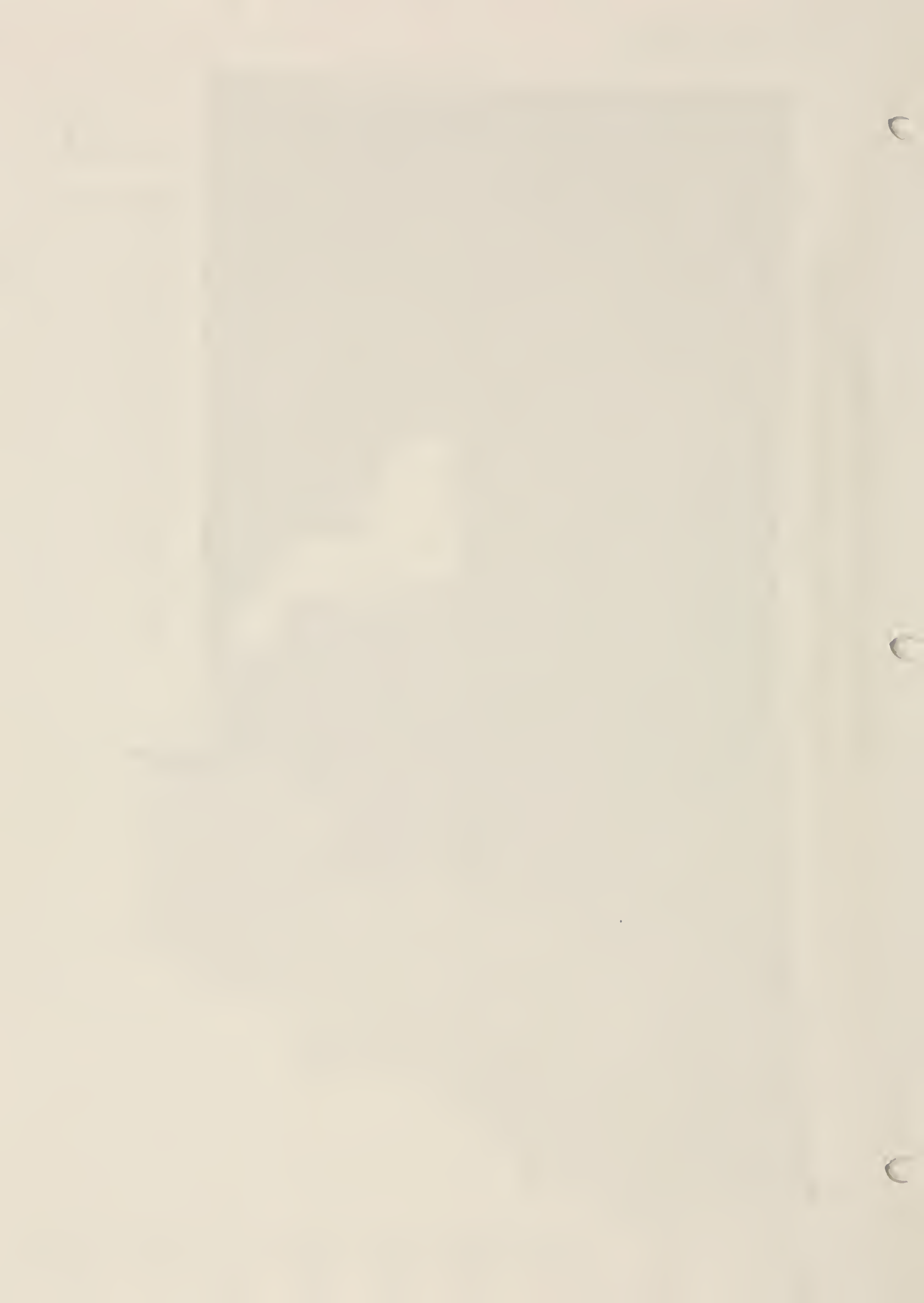
Mountain-Pacific Quality Health Foundation

Montana Personal Care Assistance and Self Direct Services Map



White area will be shared by the nurses traveling to that area (Jennifer or Rona)



Beaverhead County
2 South Pacific CL8
Dillon MT 59725
Phone: (406) 683-3794
FAX: (406) 683-5776

Big Horn County
County Courthouse
PO Box 908
Hardin MT 59034
Phone: (406) 665-9840
FAX: (406) 665-9844

Blaine County
48 Second Ave, Suite 200
Havre MT 59501
Phone: (406) 265-1233
FAX: (406) 357-2199

Broadwater County
124 North Cedar
Townsend MT 59644
Phone: (406) 266-5580
FAX: (406) 266-3158

Carbon County
206 North Broadway
PO Box 1410
Red Lodge MT 59068
Phone: (406) 446-3729
FAX: (406) 446-2640

Carter County
10 West Fallon
PO Box 1017
Baker MT 59313
Phone: (406) 778-3846
FAX: (406) 778-3831

Cascade County
2300 12th Avenue S #211
Great Falls MT 59405
Phone: (406) 727-7746
FAX: (406) 761-8663

Chouteau County
1020 13th Street
PO Box 459
Fort Benton MT 59442
Phone: (406) 622-5414
FAX: (406) 622-3848

Custer County
708 Palmer
PO Box 880
Miles City MT 59301
Phone: (406) 232-1385
FAX: (406) 232-6755

Daniels County
Courthouse -
100 W Laurel Ave.
Plentywood, MT 59254
Phone: (406) 765-1770
FAX: (406) 765-2917

Dawson County
218 West Bell, Suite 203
Glendive MT 59330
Phone: (406) 377-4963
FAX: (406) 377-3221

Deer Lodge County
307 Park, Room #305
Anaconda, Montana 59711
Phone: (406) 563-3448
FAX: (406) 563-7279

Fallon County
10 West Fallon
PO Box 1017
Baker MT 59313
Phone: (406) 778-3846
FAX: (406) 778-3431

Fergus County
300 First Avenue North #201
Lewistown MT 59457
Phone: (406) 538-7731
FAX: (406) 537-8419

Flathead County
PO Drawer 310
Kalispell MT 59903
Phone: (406) 751-5950
FAX: (406) 751-5979

Gallatin County
220 West Lamme
Northside Suite 2nd Floor
Bozeman MT 59715
Phone: (406) 585-9984
FAX: (406) 585-7178

Garfield County
708 Palmer
PO Box 880
Miles City MT 59301
Phone: (406) 232-1385
FAX: (406) 232-6755

Glacier County
304 N Piegan St Main Stream
PO Box 588
Browning MT 59417
Phone: (406) 338-5171
FAX: (406) 338-7530

1210 East Main
Courthouse Annex
Cut Bank MT 59427
Phone: (406) 873-5534
FAX: (406) 873-5859

Golden Valley County
26 Main Street
Roundup MT 59072
Phone: (406) 323-2107
FAX: (406) 323-2007

Granite County
220 N Sansome
Philipsburg MT 59858
Phone: (406) 859-0009
FAX: (406) 859-3817

Hill County
48 Second Avenue, #200
Havre MT 59501
Phone: (406) 265-1233
FAX: (406) 262-2879

Jefferson County
114 S Washington
PO Box H
Boulder MT 59632
Phone: (406) 225-4116
FAX: (406) 225-4023

Judith Basin County
300 First Avenue North #201
Lewistown MT 59457
Phone: (406) 538-7731
FAX: (406) 537-8419

Lake County
830 1/2 Shoreline Drive
PO Box 268
Polson MT 59860
Phone: (406) 883-3828
FAX: (406) 883-3897

Lewis & Clark County
316 North Park
PO Box 817
Helena MT 59624
Phone: (406) 444-2030
FAX: (406) 444-1681

Liberty County
County Courthouse
PO Box 459
Chester MT 59522
Phone: (406) 622-5414
FAX: (406) 759-5799

Lincoln County
117 Commerce Way
Libby MT 59923
Phone: (406) 293-3757
FAX: (406) 293-9447

Madison County
104 1/2 South Madison Street
PO Box 527
Twin Bridges MT 59754
Phone: (406) 684-5861
FAX: (406) 684-5597

McCone County
221 5th Street SW
Sidney MT 59270
Phone: (406) 433-1903
FAX: (406) 433-3601

Meagher County
220 East Park
Livingston MT 59047
Phone: (406) 222-7402
FAX: (406) 222-5742

Mineral County
305 West Main
PO Box 368
Superior MT 59872
Phone: (406) 822-4809
FAX: (406) 822-4819

Missoula County
610 Woody Street
Missoula MT 59802
Phone: (406) 523-4100
FAX: (406) 523-4150

Musselshell County
26 Main Street
Roundup MT 59072
Phone: (406) 323-2107
FAX: (406) 323-2007

Park County
220 East Park
Livingston MT 59047
Phone: (406) 222-7402
FAX: (406) 222-5742

Petroleum County
300 First Avenue N #201
Lewistown MT 59457
Phone: (406) 538-7731
FAX: (406) 537-8419

Phillips County
County Courthouse
PO Box 1333
Malta MT 59538
Phone: (406) 654-2252
FAX: (406) 654-2254

Pondera County
300 N Virginia Street #312
Conrad MT 59425
Phone: (406) 278-5142
FAX: (406) 278-5751

Powder River County
708 Palmer
PO Box 880
Miles City MT 59301
Phone: (406) 232-1385
FAX: (406) 232-6755

Powell County
409 Missouri
Deer Lodge MT 59722
Phone: (406) 846-3680
FAX: (406) 846-2784

Prairie County
708 Palmer
PO Box 880
Miles City MT 59301
Phone: (406) 232-1385
FAX: (406) 232-6755

Ravalli County
108 Pinckney Street
Hamilton MT 59840
Phone: (406) 363-1961
FAX: (406) 363-7553

Richland County
221 5th Street SW
Sidney MT 59270
Phone: (406) 433-1903
FAX: (406) 433-3601

Roosevelt County
100 Main Street
Wolf Point MT 59201
Phone: (406) 653-3520
FAX: (406) 653-3523

Rosebud County
1093 Main Street
PO Box 241
Forsyth MT 59327
Phone: (406) 356-7918
FAX: (406) 748-3607

PO Box 750
Colstrip MT 59323
Phone: (406) 748-3622
FAX: (406) 748-2659

Sanders County
#2 Tradewinds Way
Thompson Falls MT 59873
Phone: (406) 827-4317
FAX: (406) 827-9870

Sheridan County
Courthouse -
100 W Laurel Avenue
Plentywood MT 59254
Phone: (406) 765-1770
FAX: (406) 765-2917

Silver Bow County
700 Casey Street
Butte MT 59701
Phone: (406) 496-4950
FAX: (406) 496-4966

Stillwater County
725 9th Street #201
PO Box 456
Columbus MT 59019
Phone: (406) 322-4821
FAX: (406) 322-4643

Sweet Grass County
5th & Hooper Streets
Rooms 4 & 6
PO Box 239
Big Timber MT 59011
Phone: (406) 932-5267
FAX: (406) 932-4979

Teton County
18 1st Street NW
Choteau MT 59422
Phone: (406) 466-5592
FAX: (406) 466-5783

Toole County
County Courthouse
Shelby MT 59474
Phone: (406) 434-5022
FAX: (406) 434-7054

Treasure County
1093 Main Street
PO Box 241
Forsyth MT 59327
Phone: (406) 356-7918
FAX: (406) 356-7166

Valley County
501 Court Square
PO Box 9
Glasgow MT 59230
Phone: (406) 228-8221
FAX: (406) 228-4030

Wheatland County
County Courthouse
PO Box 4920
Harlowton MT 59036
Phone: (406) 632-4895
FAX: (406) 632-5654

Wibaux County
10 West Fallon
PO Box 1017
Baker MT 59313
Phone: (406) 778-3846
FAX: (406) 778-3431

Yellowstone County
2525 4th Avenue North
Suite 309
Billings MT 59101
Phone: (406) 657-3120
FAX: (406) 657-3178

FORMS AND INSTRUCTIONS--The provider agency is required to use the following Department forms in providing self-directed personal assistance services.

Any additional forms developed by the provider agency must be approved by the Department.

FORM NUMBER	FORM NAME
DPHHS-MA-151	Personal Assistance Services Request for Prior Authorization
DPHHS-MA-153	Self-Directed Personal Assistance Services Health Maintenance Report.
DPHHS-MA-156	Self-Directed Personal Assistance Services Plan/Health Care Professional Approval
DPHHS-MA-157	Self-Directed Personal Assistance Services Consumer Profile.
DPHHS-MA-158	Self-Directed Personal Assistance Services Delivery Record.
DPHHS-MA-159	Self-Directed Personal Assistance Services Consumer Agreement.
DPHHS-MA-160	Self-Directed Personal Assistance Services Information for the Health Care Professional.
DPHHS-MA-164	Self-Directed Personal Assistance Amendment Form.
DPHHS-MA-166	Self-Directed Personal Assistance Personal Representative Agreement.

To order personal assistance forms, the provider agency must complete a Department requisition form and send it to the Department (Refer to SDPAS 900-10).

This table is provided to outline the required documentation per event.

Remember that appropriate chart notes should be utilized to supplement required forms.

EVENT	REQUIRED DOCUMENTATION
Intake	Services Plan/Health Care Professional Approval Consumer or Personal Representative Agreement Consumer Profile Prior Authorization
Recertification-180th Day Visit	Consumer Profile, if necessary Prior Authorization
Annual Review	Services Plan/Health Care Professional Approval Consumer or Personal Representative Statement Consumer Profile, if necessary Prior Authorization
Change in Condition	Consumer Profile Prior Authorization
Change in Schedule	Amendment Form
Quarterly	Quarterly Utilization Report Health Maintenance Report

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX **SUBJECT:** Personal Assistance Services Request for Prior Authorization (DPHHS-MA-151)

PURPOSE: This form is to be used by the provider agency to request authorization of services by DPHHS staff prior to service delivery.

PROCEDURE: The provider agency fills out the form and sends it to the Regional Program Officer (RPO). The provider agency may telephone the RPO for verbal authorization and indicate this on the form. The form must still be forwarded to the RPO with a copy of the most current service plan.

DISTRIBUTION: The RPO will review and sign the form keeping the yellow and pink copies before sending the white copy back to the provider agency.

INSTRUCTIONS: IDENTIFYING INFORMATION--Complete all of the identifying information.

Diagnosis--List the major diagnoses of the recipient.

Check specific reason for request. If the reason is not listed, check "Other" and state reason.

Reason for request--Provide narrative explaining the reason checked in prior section. Provide sufficient information to justify services. Attach copy of the plan of care.

Prior authorization period requested--List the time period that the prior authorization is being requested for.

No. of Hours--Indicate the number of weekly hours requested.

Nurse Signature--The nurse of the Personal Assistance Services Agency signs on this line.

Self-Directed Provider Agency Signature--The person who is requesting the authorization should sign and date on this line.

Agency--Indicate which agency they represent and provide phone number.

FOR MEDICAID USE ONLY--This section will be completed by the Regional Program Officer.

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DPHHS-MA-151
(Rev. 7/99)

STATE OF MONTANA
Department of Public Health and Human Services

PERSONAL ASSISTANCE SERVICES
REQUEST FOR PRIOR AUTHORIZATION

Recipient Name: ______________________ Medical Record No: ____________

Address: ______________________

County: ______________ Medicaid No: ____________

Diagnoses: ______________________

______ Authorization to provide more than 40 hours of personal assistance services per week to recipient.

- ______ Absence of Informal Caregiver
- ______ Attendant Training
- ______ Acute Episode
- ______ Post Hospitalization

______ Authorization for services in a group home or foster home.

______ Authorization for out-of-state services.

______ Authorization for services to recipient under age 21.

______ Authorization for Self-Directed services.

______ Other: ______________________

Reason for request (a copy of the service plan must be attached): ______________________

Prior authorization period requested: ______________ No. of Hours: ________

Nurse Supervisor Signature: ______________ Date: ________
or
Self-Directed Provider Agency: ______________ Date: ________

Agency: ______________ Phone No: ________

FOR MEDICAID USE ONLY

______ Approved

______ Approved with Condition (specify condition): ______________________

______ Not approved (specify reason): ______________________

Signature: ______________________ Date: ________

Distribution: White-Agency; Yellow-Regional Program Officer

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX **SUBJECT:** Self-Directed Personal Assistance Services Quarterly Utilization Report

PURPOSE: To assist the Department in budgeting and forecasting to insure the financial viability of the program.

FREQUENCY: This report must be filed on a quarterly basis, the schedule is as follows:

Q1 July 1 - September 30 Due: October 31
Q2 October 1 - December 31 Due: January 31
Q3 January 1 - March 30 Due: April 30
Q4 April 1 - June 30 Due: July 31

SUBMISSION: Submit Reports to:

Personal Assistance Program
Senior & Long Term Care Division
PO Box 4210
Helena MT 59604

INSTRUCTIONS:

Client Count:

Provide an accurate count of recipients receiving **state plan** self-directed personal assistance services on the first (a) and last (b) day of the month for each month of the quarter. Determine the net change (b-a) in client count for each month.

EXAMPLE:

	Month 1	Month 2	Month 3
First Day (a)	35	38	37
Last Day (b)	38	37	40
Net Change (b-a)	+3	-1	+3

Utilization of services:

Complete the following table by providing an accurate number of units of service delivered during each month of the quarter.

Total Month 1,2 & 3 and place in column (1). Enter the appropriate unit rate:

a. $2.87 with wage plan;
b. $2.75 without wage plan; or
c. established rate due to negotiated wage plan.

Then multiply by unit rate to obtain cost by service type, record in column (2). Total column (2) and record in the box (3) below.

EXAMPLE:

	Month 1	Month 2	Month 3	Totals (1)	Unit	Cost (2)
Z0564 - Attendant Units	1500	1540	1650	4690	$2.87	$13,460.30
Z0569 - Oversight	100	152	126	378	$2.87	$ 1,084.86
A0800 - Mileage	250	150	500	900	$ .31	$ 279.00
Total Cost for Services						(3) $14,824.16

A copy of the Quarterly Utilization Report is on page 3. Copy the report from the manual as the department does not supply this report.

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(Rev. 1/00)

STATE OF MONTANA
Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES QUARTERLY UTILIZATION REPORT

AGENCY:______________________________ PROVIDER ID#:______________

CONTACT PERSON (PLEASE PRINT)______________________________________

PHONE NUMBER:____________________ DATE REPORT IS COMPLETED:__________ ___

For the period of: (circle one)
Q1 July - September
Q2 October - December
Q3 January - March
Q4 April - June

Client Count: Please provide an accurate count of recipients receiving **state plan** personal assistance services on the first (a) and last (b) day of the month for each month of the quarter. Determine the net change (b-a) in client count for each month.

	Month 1	Month 2	Month 3
First Day (a)			
Last Day (b)			
Net Change (b-a)			

Utilization of services: Complete the following table by providing an accurate number of units of service delivered during each month of the quarter.

Total Month 1,2 & 3 and place in column (1). Enter the appropriate unit rate. Then multiply by unit rate to obtain cost by service type, record in column (2). Total Column (2) and record in the box (3) below.

	Month 1	Month 2	Month 3	Totals (1)	Unit	Cost (2)
Z0564 - Attendant Units					$	
Z0569 - Oversight					$	
A0800 - Mileage					$ .31	
Total Cost for Services						(3)

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX **SUBJECT:** Self-Directed Personal Assistance Services Health Maintenance Report (DPHHS MA-153)

PURPOSE: This form provides information to track consumers who have authorization to perform health maintenance tasks.

PROCEDURE: The provider must complete this report at the end of every quarter. The completed form must be submitted to the Department by the end of the month following the end of the quarter. (See SDPAS 405 for the schedule.)

DISTRIBUTION: Submit the original to the Department. Providers should retain a copy for their records.

INSTRUCTIONS: Complete Provider Agency and Provider Number with the appropriate information.

Signature and Date--Signature of the individual completing the report and the date it was accomplished.

Recipient Name--Name of the individual who utilized your agency to receive self-directed services during the quarter.

Medicaid ID--The individual's recipient identification number.

Medication Administration, Bowel Treatment, Urinary System Management, Wound Care and None--Check the appropriate column to indicate which tasks are being provided under the self-directed personal assistance program. If the individual is not managing any health maintenance tasks, check none.

Number of Units Authorized for Health Maintenance Per Week--Enter the number of units dedicated to the provision of health maintenance activities as computed on the Self-Directed Personal Assistance Services Consumer Profile (DPHHS-MA-157).

Example--An example of a properly completed form is attached.

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(New 6/96)

STATE OF MONTANA
Department of Public Health and Human Services

EXAMPLE

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES
HEALTH MAINTENANCE REPORT

Provider Agency: PDQ INC

Provider Number: 124578

Signature: ____________

Date: 1/12/9x

RECIPIENT NAME	MEDICAID ID	MEDICATION ADMINISTRATION	BOWEL TREATMENT	URINARY SYSTEM MANAGEMENT	WOUND CARE	NONE	NO. OF UNITS (NOT HOURS) AUTHORIZED FOR HEALTH MAINTENANCE PER WEEK
JACK SPRAT	123 45 6789	X					2
MOM GOOSE	111-22-3444	X			X		8
BARNEY RUBBLE	112-33-4555					X	0

SDPAS 900-4

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX **SUBJECT:** Self-Directed Personal Assistance Services Plan/Health Care Professional Approval (DPHHS-MA-156)

PURPOSE: This form incorporates the self-directed personal assistance services plan which the consumer will use as a planning tool and the health care professional's approval of services. It will also serve as the consumer's enrollment form.

PROCEDURE: The tasks and hours authorized are completed by the provider agency in conjunction with the Consumer Profile. The remaining information on this form is completed by the consumer. The consumer may request that the agency or another person help in completing the form.

DISTRIBUTION: After the consumer obtains the health care professional's signature, the consumer gives the pink copy to the health care professional, sends the providing agency the white copy and keeps the yellow copy.

INSTRUCTIONS: Intake--Check the intake box if this is the first visit.

Recertification--Check the recertification box if the plan is being reviewed at the end of 180 days or if the plan is being changed due to a significant change in the consumer's condition.

HCBS--Check the HCBS box if you are also a Home and Community Based Services consumer.

Change in Hours--Check this box if the number scheduled or total of authorized hours have changed.

Identifying Information--Complete all of the identifying information

Medical Diagnosis--List your major diagnoses and dates of onset if known.

Allergies--List all known allergies.

Medications--List the medications including their dosage and frequency.

State Plan Tasks-- Check the tasks that are to be completed. These tasks must be accounted for on the consumer profile. Note weekly hours authorized.

Health Maintenance Activities--Check those tasks that you wish the personal assistant to complete (Upon approval from health care professional). Note weekly hours authorized.

HCBS Only--Check those tasks which you receive from HCBS. These services must be prior authorized by a HCBS Case Management Team. Note weekly hours authorized by the CMT.

Household tasks may not exceed one-third of the total State Plan hours. (Refer to SDPAS 900-6 for a table of hours.)

Emergency Backup Plan -- Consumer documents his/her back-up plan for the completion of personal assistance services and health maintenance tasks in the event that the scheduled personal assistant is unable to, or fails to, show for work. This plan would precede an emergency order for agency managed personal assistance program or home health agency services for authorized health maintenance tasks.

Recruitment and Training -- Consumer documents his/her plan for recruiting and maintaining assistants. Include any specific requirements for training and education you are looking for.

Consumer Statement of Participation--Provide comments on your need for services, living

situation, and any other factors which may affect the delivery of personal assistance services. Indicate why you believe your health care professional should authorize participation and/or the management of health maintenance activities.

Consumer Short & Long Term Goals -- Short term goals should address the immediate outcome of self-directed personal assistance services. Long term goals should include how self-directed personal assistance services will meet your needs until the recertification date.

Consumer Signature/Date -- The consumer's signature and date is required at the time of intake.

Agency Signature/Date--The agency employee completing the intake must sign and date the form.

Health Care Professional Signature/Date--The health care professional is required to sign and date the form prior to initiation of services. A verbal approval notation is **NOT** acceptable.

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SELF-DIRECTED PERSONAL ASSISTANCE SERVICES PLAN/HEALTH CARE PROFESSIONAL APPROVAL

☐ INTAKE ☐ RECERTIFICATION ☐ HCBS ☐ CHANGE IN HOURS

Consumer Name: ______ Medicaid Number: ______

D.O.B. ______ Age: ____ Sex: M F Phone Number: ______

Address: ______
(Street) (City) (Zip Code)

Health Care Professional: ______ Phone No: ______

Address: ______
(Street) (City) (Zip Code)

Medical Diagnoses (include dates of onset):

Allergies:

Medications (include dosage and frequency):

STATE PLAN TASKS: HOURS AUTHORIZED:

	Bathing		Dressing		Routine Hair/Skin Care		Exercise
	Eating		Laundry		Assistance with Medications		Other
	Toileting		Cleaning		Meal Preparation		
	Escort		Shopping		Transfer/Ambulate		

HEALTH MAINTENANCE ACTIVITIES: HOURS AUTHORIZED:

	Admin. Of Medications		Bowel Treatment		Urinary System Management		Wound Care

HCBS TASKS ONLY: HOURS AUTHORIZED:

	Socialization		Supervision		Social Transport		

Emergency Backup Plan

Attendant Services:

Health Maintenance Tasks:

Recruitment and Training

Discuss:

Consumer Statement of Participation:

Consumer's Short Term Objective & Long Term Goals:

Consumer: ______ Date: ______

Agency: ______ Date: ______

Health Care Prof: ______ Date: ______

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX **SUBJECT:** Self-Directed Personal Assistance Services Consumer Profile (DPHHS-MA-157)

REVISED: 1/1/99

PURPOSE:

To provide an instrument for collecting and documenting essential information needed to establish the consumer's functional limitations and ability to perform activities of daily living.

To document information on service planning issues for personal assistance services.

To provide a worksheet for determining the weekly units needed by the consumer.

PROCEDURE:

The Consumer Profile should be completed at the initial intake for services, at the re-certification date and whenever a significant change in the consumer's condition occurs causing the service need to change.

When you are updating or recertifying you must ask the consumer each question in Part 1. Do not revise any item scored without determining the current correct score for each item.

When there is a change in tasks or units, either complete a new Part 2 or update the current Part 2. Initial each updated item.

Complete a new profile if the update makes the form too difficult to read or understand and at every recertification date.

INSTRUCTIONS:

Complete the identifying information at the top of the page and indicate the date of the initial and/or update.

Companion Case Name - enter the name of a person (if any) residing in the same household who is also receiving personal assistance services.

PART 1 Instructions:

Complete Part 1 during an on-site visit with the consumer in their home. Encourage the consumer and/or the consumer's immediately involved representative to actively participate in the process.

Scoring: Rate the consumer according to the following scale:

0 = No functional impairment. The individual is able to conduct the activities without difficulty and has no need for assistance.

1 = Minimal/Mild functional impairment. The individual is able to conduct activities with minimal difficulty and needs minimal assistance.

2 = Extensive/Severe functional impairment. The individual has extensive difficulty carrying out activities and needs extensive assistance.

3 = Total functional impairment. The individual is completely unable to carry out any part of the activity.

You must decide which of the four impairment levels best fits the consumer being reviewed. An impairment in this context is a functional limitation, i.e., a limitation in the ability to carry out an activity or function. A person has an impairment with respect to a particular activity if he is limited, either physically or mentally in his ability to carry out that activity. "0" and "3" are absolutes in the sense that they indicate no functional impairment or total dependency. For example, if a consumer can perform any of the dressing tasks for himself a "3" is not appropriate. If he can

perform the dressing task without difficulty, a "0" is appropriate.

If a consumer is able to conduct an activity only with difficulty, and the difficulty is such that the consumer frequently cannot complete some part of the activity, then the consumer is impaired, even if the consumer at other times can complete the entire activity. In addition, if the degree of difficulty is such that the consumer should have at least minimal assistance with that activity, then the consumer is impaired, even if the consumer can (with difficulty) conduct the activity without assistance. If the difficulty with an activity does not affect the consumer's conduct of the activity or does not cause any problems for the consumer, the consumer is not impaired.

The first time an item is addressed, use the wording of the question as written, and then explain or paraphrase if necessary. Ask follow-up questions if you are in doubt or need to verify the first response. Have an open discussion with the consumer regarding their needs to insure that all service needs have been accounted for.

<u>You must enter a score for each question.</u>

As you score, remember that Form DPHHS-MA-157 is designed to assess a consumer's capacity for self-assistance. Score each item according to this capacity for self-care and not according to the consumer's access to a resource to assist with the task. In scoring each item, use the consumer's response, and your own observations. To determine the severity of the consumer's impairment, consider the following factors:

1. Consumer Perception of the Impairment-Does the consumer view the impairment as a major or minor problem?

2. Congruence-Is the consumer's response to a particular question consistent with the consumer's response to other questions and also consistent with what you have observed?

3. Consumer History-Probe for an understanding of the consumer's history as it relates to the current situation and of the consumer's attitude about the severity of the impairment. Has the consumer always kept a messy house and is not, therefore, concerned because he is unable to perform housekeeping tasks? Has the consumer always eaten only one meal a day and is not, therefore, interested in eating more often? How has the impairment changed the consumer's lifestyle?

4. Consumer's right to self-determination vs. danger to self-consider the consequence to the consumer if he chooses not to take medications, bathe, adhere to a special diet, etc.

5. Lack of Facilities-Absence of facilities for bathing, laundry, telephoning, or meal preparation may indicate an impairment. The impairment and its degree will depend on accessibility to the facility, on the consumer's ability to use the facility, and on the consumer's ability to make satisfactory accommodations in the absence of the facility.

6. Adaptation-If the consumer has adapted his physical environment or clothing

to the extent that he is able to function without assistance, the degree of impairment will be lessened, but the consumer will still have an impairment.

Use the following examples for each item to help you differentiate between scores of " 1 " and " 2 ".

	1 - Minimal/Mild Impairment	2 = Extensive/Severe Impairment
1. Bathing	Consumer may set out supplies. Consumer needs standby assistance for safety or reminding. Consumer may accomplish bath by using a chair or other adaptive device for assistance.	Consumer needs help getting in and out of tub or shower or drawing and testing temperature of water. Consumer needs help with actual bathing of body due to inability to reach or grasp. Consumer always needs adaptive devices or can only manage sponge baths due to disabilities. Consumer cannot haul or manage heating of water in a home without modern conveniences.
2. Dressing	Consumer needs *occasional* help with zippers, buttons, or putting on shoes and socks. Consumer may need help laying out and selecting clothes. Consumer needs reminding or monitoring for completion of dressing	Consumer needs help with zippers, buttons, or shoes and socks. Consumer needs help getting into garments, that is, putting arms in sleeves, legs in pants, or pulling up pants. Consumer may dress totally inappropriately without help or would not finish dressing without physical assistance.
3. Exercising	Consumer may need reminding to complete their exercise routine. Consumer may require stand-by assistance for safety.	Consumer may need some assistance in completing exercise routine. Consumer may need support or guidance.
4. Grooming	Consumer may set out supplies. Consumer needs standby assistance for safety or reminding. Consumer may accomplish tasks an adaptive device for assistance.	Consumer needs to have help with shaving *or* shampooing, etc., because of inability to see well, to reach, or to successfully use equipment. Consumer needs someone to put lotion on body or to comb or brush hair.
5. Toileting	Consumer has instances of urinary incontinence, and needs help because of this from time to time. Fecal incontinence does not occur unless consumer has a specific illness episode.	Consumer often is unable to get to the bathroom on time to urinate. Consumer has occasional episodes of fecal incontinence. Consumer may wear diapers to manage the problem and needs some assistance with them.

	1 - Minimal/Mild Impairment	2 = Extensive/Severe Impairment
6. Transferring	Consumer usually can get out of bed or chair with minimal or standby assistance. Consumer may accomplish transfer without help, but needs standby assistance for safety. Consumer needs assistance with positioning	Consumer usually needs hands-on assistance when rising to a standing position or moving into a wheelchair to prevent losing balance or falling. Consumer is able to help with the transfer by holding on, pivoting, and/or supporting himself. Consumer dependent for positioning.
7. Ambulation	Consumer walks alone without assistance for only short distances. Consumer can walk with minimal difficulty using an assistive device or by holding onto walls or furniture.	Consumer has considerable difficulty walking even with an assistive device. Consumer can walk only with assistance from another person. Consumer never walks alone outdoors without assistance. Consumer may use a wheelchair periodically.
8. Meal Preparation	Consumer can only fix meals that require simple preparation. Consumer can usually open cans and heat food, use microwave or oven, prepare some vegetables, cook eggs and small cuts of meat. Consumer may have difficulty with cutting meats or other foods.	Consumer can only prepare simple cold foods like sandwiches, purchase snacks and cereal, or war-up food prepared by others, consumer has difficulty opening cans and preparing fresh foods for cooking. Consumer regularly has difficulty seeing or turning burner on and off and sometimes forgets to turn burners off.
9. Eating	Consumer may need standby assistance but only occasional physical help. Consumer needs verbal reminders or encouragement. Consumer eats with adaptive devices but requires help with their positioning	Consumer usually needs extensive hands-on assistance with eating. Consumer may hold eating utensils but needs continuous assistance during meals. Consumer would not complete meal without continual help. Spoon feeding of most foods is required, but consumer can eat some finger foods.
10. Bowel Program	Consumer may need occasional assistance with suppository.	Consumer requires assistance with on-going bowel program.
11. Wound Care	Consumer may need occasional help with reddened areas. Consumer may need some help with dressing changes but is able to assist in the care themselves.	Consumer has on-going problem with decubiti and is unable to do self-care. Consumer requires help post-op with dressing changes and is unable to assist with self care.

	1 - Minimal/Mild Impairment	2 = Extensive/Severe Impairment
12. Urinary System Management	Consumer needs occasional help with self-cath or catheter care. May also require assistance with colostomy care.	Consumer needs on-going help with catheter care, insertion, etc. Consumer is unable to contribute meaningful assistance to complete task. Consumer needs assistance with colostomy care.
13. Medication Administration	Consumer requires occasional help in taking medications. Consumer requires occasional help in applying prescription medications to skin or reddened areas. Consumer requires occasional help with eye-drops.	Consumer requires consistent help in taking medications, eye drops, etc. Consumer requires help with injections or medications via tube. Consumer is unable to contribute meaningful assistance to complete task.
14. Escort	Consumer requires minimal assistance with ambulation, transfer, (un)dressing or toileting en route to or while at the medical appointment. Consumer does not have family or caregiver to assist. Cannot utilize Medicaid transportation.	Consumer requires assistance with two or more; ambulation, transfer, (un)dressing or toileting en route to or at the medical appointment. Consumer does not have family or caregiver to assist. Cannot utilize Medicaid transportation.
15. Cleaning	Consumer can do most tasks around the house, like picking up, dusting, washing dishes, sweeping, straightening the bed, carrying out trash, light vacuuming, or cleaning sinks. Consumer cannot move heavy furniture or do extensive scrubbing or mopping.	Consumer is able to do only very light housework like dusting, washing a few dishes, or straightening up magazines/ newspapers. Consumer can not see well enough or does not have the strength or flexibility to sweep floors, change bed linens, or carry heavy objects.
16. Laundry	Consumer does hand washing but has difficulty wringing and hanging heavy laundry to dry. Consumer may be able to put clothes in washing machine, sort clothes, fold them, and put them away with only minimal difficulty. Consumer can also assist in these ways if a Laundromat is used. Consumer may have strength but may not be able to see or turn washer dials, or may require supervision or instruction to use a washer.	Consumer may do light hand washing but cannot bend or lift or carry loads of clothes to manage most laundry. Consumer cannot hang clothes out at all or get them off a line, but may fold them and help put them away. Consumer may not be able to wring out clothes without help. If a Laundromat is used, the consumer has considerable difficulty getting there.
17. Shopping	Consumer decides what to buy and can shop if someone goes along to help. Consumer may shop by telephone. Consumer may have difficulty carrying or storing groceries.	Consumer may still decide what to buy, but seldom, if ever, goes to a store. Consumer may not be able to shop by telephone due to communication difficulties. Consumer regularly cannot carry or store most of the purchases without help.
Total Score	Enter the total score of Items 1-17.	

PART 2 -- TASK/HOUR GUIDE

Service Arrangement - Enter the following codes to indicate the service provider under the "P" column.

C = Caregiver. Use "C" if the service is being performed by a relative, neighbor, or friend on a regular basis.

S = Self. Use "S" if the applicant/ consumer performs the task without assistance.

P = Purchased. Use "P" if the service is to be purchased, through the personal assistance services program.

A = Other agency. Use "A" when another community agency is performing the service; i.e. Home Health, Homemaker, Senior Companion, Private Duty Nursing, etc.

Minutes Per Day - The times given for each task and impairment level are maximum times, and the actual time needed in each case will vary from consumer to consumer. See Page 2 for additional information about tasks and times.

For each task to be authorized, enter the daily number of minutes needed to conduct that task. Use the time shown for a task only if the consumer needs that amount of time. This is, always use less time if the maximum on the Task/Hour Guide is more than the consumer needs.

DO NOT ROUTINELY AUTHORIZE THE MAXIMUM.

A task may be authorized if it is performed at least once a month by the provider. (escort may be shown as PRN). Time allotted for each task must be prorated to a weekly amount. **Example:** Laundry 1/mo. X 120 mins divided 4.33 = 28 minutes per week. This would be rounded to 30 minutes or two units.

Days per week - For each task to be authorized, enter the number of days per week the personal assistant will conduct that task. Enter in the comments section if the task is performed less than once a week and pro-rate appropriately.

Subtotal PC Minutes--Add the total minutes for each task to obtain the subtotal for personal assistance tasks.

NOTE: When dividing minutes by 15, round down or up to the nearest whole unit. For example:

1205 min ÷ 15 = 80.33 units
round to 80 units

or

1195 min ÷ 15 = 79.66 units
round to 80 units

Health Maintenance Activities - Estimate amount of time needed to complete these tasks. Do not allow the entire time necessary to complete a task if other household tasks can be performed while waiting for conclusion of health maintenance task. (For instance, household cleaning can be done while waiting for results of bowel program.)

Medication Administration - Includes reminders for individuals who can self medicate. However, time for reminders may not be allowed. This task can be performed within total authorized hours.

Subtotal HMA Minutes - Add the total minutes for each task to obtain the subtotal for health maintenance activities. See notation for rounding units under Subtotal PC Minutes.

Household, Laundry, Shopping - Estimate the amount of time needed to complete these tasks. Refer to the Household Tasks table for the limit of hours available based on the time authorized for personal assistance services. DO NOT AUTHORIZE THE ENTIRE AMOUNT UNLESS IT IS NEEDED. When a recipient lives with a family, it is expected that the family will provide most household, shopping and escort services. If there is a companion case, time allocated for general household task should be divided between the two (or more) recipients.

Escort - **DO NOT** estimate the amount of time to be utilized. The consumer must document mileage and destination and time when escort services are utilized. Consumer must still qualify to use the services. It is alright to exceed authorized hours to provide bona fide escort services.

Subtotal HT Minutes - Add the total for each task to obtain the subtotal for household tasks and compare against the Household Tasks table. Adjust if necessary. See notation for rounding under Subtotal PC Minutes.

Total Units - Indicate the total number of units being authorized.

Signature - Both the provider agency employee and the consumer need to sign this form at the time the initial intake is completed. An update to the form must be initialized by both parties.

Page 2 - Page 2 provides additional information you should use to determine the amount of time to authorize for any particular task.

It also contains some of the sub-task involved in each task, and this listing is not considered inclusive. You should carefully consider whether the consumer needs total assistance or assistance with only one or more of the sub-tasks when calculating time on Part 2.

The check boxes by each sub-task are optional and may be marked at your discretion. In addition, you should refer to this information at recertification and updates.

PERSONAL ASSISTANCE HOURS	MAXIMUM # OF HOUSEHOLD TASKS HOURS	TOTAL
1	.5	1.5
2	1.0	3.0
3	1.5	4.5
4	2.0	6.0
5	2.5	7.5
6	3.0	9.0
7	3.5	10.5
8	4.0	12.0
9	4.5	13.5
10	5.0	15.0
11	5.5	16.5
12	6.0	18.0
13	6.5	19.5
14	7.0	21.0
15	7.5	22.5
16	8.0	24.0
17	8.5	25.5
18	9.0	27.0
19	9.5	28.5
20	10.0	30.0
21	10.5	31.5
22	11.0	33.0
23	11.5	34.5
24	12.0	36.0
25	12.5	37.5
26	13.0	39.0
27	13.0	40.0
28	12.0	40.0
29	11.0	40.0
30	10.0	40.0
31	9.0	40.0
32	8.0	40.0
33	7.0	40.0
34	6.0	40.0
35	5.0	40.0
36	4.0	40.0
37	3.0	40.0
38	2.0	40.0
39	1.0	40.0
40	.0	40.0

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SELF-DIRECTED PERSONAL ASSISTANCE SERVICES
CONSUMER PROFILE

Consumer Name:	No:	Initial:
Companion Case Name:	No:	Update:

PART 1 - Consumer Functional Assessment | **PART 2 - HOUR/GUIDE**

Personal Care Tasks		I	P	Min. per day x days per wk = total min.
1. Do you have difficulties taking a bath or shower?	Bathing			max=45 X =
2. Can you dress yourself?	Dressing			max=30 X =
3. Do you need assistance with an exercise program?	Exercise			max=30 X =
4. Can you groom yourself? (wash, shave, comb hair, brush teeth)	Grooming			max=M-30 F-45 X =
5. Do you have any difficulties getting to and using the bathroom?	Toileting			max=30 X =
6. Can you get in and out of your bed or chair?	Transferring			max=15 X =
7. Are you able to walk without help?	Ambulation			max=15 X =
8. Do you need assistance fixing your meals? (☐B ☐L ☐D☐MOW)	Meal Prep			max=90 X =
9. Do you need assistance eating?	Eating			max=30 X =
	Subtotal PC			Min ÷ 15 = Units
Health Maintenance Activities (HMA)				
10. Do you need help with a bowel treatment?	Bowel Program			X =
11. Do you need help with wound care?	Wound Care			X =
12. Do you need help with urinary system management?	Urinary Syst Mgt			X =
1[illegible] [illegible]o you need help with administration of medicine? - See Back	Med Admin			X =
	Subtotal HMA			Min ÷ 15 = Units
	TOTAL PC + HMA =			Units
Household & Escort				
14. Escort - See Back	Escort			
15. Can you clean your home? (Vacuum, dishes, dust, sweep, etc.)	Household			see back
16. Can you do your laundry? (Consumer has ☐washer ☐dryer)	Laundry			see back
17. Do you need assistance with shopping?	Shopping			max=90
	Subtotal HT			Min ÷ 15 = Units
	TOTAL PC + HMA + HM =			Units

KEY
I = Impairment
- 0 = No Impairment
- 1 = Minimal/Mild
- 2 = Extensive
- 3 = Total

P= Provider
- C = Caregiver
- P = Personal Care
- A = Other Agency
- S = Self

GENERAL - **The times shown for each task are maximums and you should not routinely authorize this amount.** The amount of time you allow for any particular task should be determined by taking into account:
- the amount of assistance the consumer will usually need;
- the availability of anyone else to assist with the task;
- which specific activities need to be accomplished;
- environmental/housing factors that may hinder or facilitate service delivery;
- consumer's unique circumstances; or
- consumer's lifestyle choices.

In general, if there is a companion case, time for each household task (cleaning, laundry, meal preparation and shopping) total time should be split between consumers.

Total Authorized Units:	Update:

I understand that this consumer profile establishes a service limit. Services provided in excess of this limit are the responsibility of the co[illegible]er unless otherwise prior authorized by the Department.

Consumer/PR:	Agency Rep:

SPECIFIC TASKS- Each task has one or more activities or sub-tasks which form the overall purchased task. When calculating times, carefully consider which activities will be purchased.

1. Bathing .... ☐ Drawing water in sink, basin or tub ☐ Hauling/heating water ☐ Laying out supplies ☐ Assisting in/out of tub/shower ☐ Sponge bathing and drying ☐ Bed bathing and drying ☐Tub bathing and drying ☐ Standby assistance for safety

2. Dressing .... ☐ Dressing consumer ☐ Undressing consumer ☐ Laying out clothes

3. Exercise .... ☐ Taking consumer for a walk ☐ Range of motion

4. Grooming ... ☐ Shaving ☐ Brushing teeth ☐ Shaving underarms, legs when consumer requests it as a necessary grooming activity ☐ Caring for nails ☐ Laying out supplies ☐ Drying hair ☐ Assisting with setting/rolling/braiding hair (Does NOT include permanents, cutting or chemical processing of hair) ☐ Combing/brushing hair ☐ Applying nonprescription lotion to skin ☐ Washing hands and face ☐ Laying out supplies

5. Toileting ... ☐ Changing diapers ☐Changing colostomy bag/emptying catheter bag ☐ Assisting on/off bed pan ☐ Assisting with use urinal ☐ Assisting with feminine hygiene needs ☐ Assisting with clothing during toileting ☐ Assisting with toilet hygiene: includes use of toilet paper and washing hands ☐ Standby assistance

6. Transfer ... ☐ Non-ambulatory movement from one stationary position to another (transfer) ☐ Adjusting/changing consumer's position in bed/chair (positioning).

7. Ambulation(Walking) ☐ Assisting consumer in rising from a sitting to a standing position and/or position for use of walking apparatus ☐ Assisting with putting on and removing leg braces and prostheses for ambulation ☐ Assisting with ambulation/using steps ☐ Standby assistance with ambulation ☐ Assistance with wheelchair ambulation

8. Meal Preparation .... ☐ Cooking full meal ☐Warming up prepared food (M.O.W.) ☐ Planning meals ☐ Helping prepare meals ☐ Cutting food for preparation ☐ Serving food ☐ Grinding and pureeing food ☐ Clean-up

9. Eating .... ☐ Spoon feeding ☐ Bottle feeding ☐ Set up of utensils/adaptive devices ☐ Assistance with using eating or drinking utensils/adaptive devices ☐ Cutting up foods ☐ Standby assistance/encouragement **NOTE:** Tube feeding is not an allowable service.

10. Bowel Treatment ... ☐ Suppository ☐ Digital Stimulation ☐ Abdominal Stimulation

11. Wound Care ... ☐ Applying prescription medications to wound ☐ Dressing changes

12. Urinary System Management ... ☐ Foley Catheter ☐ Condom Catheter ☐ Suprapubic Catheter ☐ Straight Catheter

13. Medication Administration ... ☐ Oral medications ☐ Injectable medications ☐ Medications via tube ☐ Suppositories ☐ Skin medications ☐ Eye drops ☐ Reminders Only (NO TIME SHOULD BE ALLOCATED FOR THIS TASK)

14. Escort ..... ☐ Accompanying consumer to clinic or doctor's office for the purpose of providing personal assistance during the appointment. ☐ Individual does not have caregiver or family member available to provide personal assistance during the appointment. ☐ Individual is unable to utilize Medicaid Transportation program. **NOTE:** Provider agency must document specific consumer need for Escort, all three of the above conditions must apply. Time does not need to be estimated.

15. Household Tasks .. ☐ Cleaning up after other personal care tasks, e.g., bathing, toileting, etc. ☐ Emptying and cleaning bedside commode ☐ Cleaning bathroom, i.e., tub/shower, toilet, sink, floor ☐ Changing bed linens ☐ Making bed ☐ Cleaning floor of living areas used by consumer ☐ Dusting ☐ Carrying out trash, setting out garbage for pick up ☐ Cleaning stove-top, counters, washing dishes ☐ Cleaning refrigerator and stove **NOTE:** If companion case is also receiving some cleaning tasks, the time should be split between both consumers.

16. Laundry ... ☐ Doing hand wash ☐ Gathering and sorting ☐ Loading and unloading machines in residence ☐ Using laundromat machines ☐ Hanging clothes to dry ☐ Folding and putting away clothes

Maximum WEEKLY times for laundry:

Consumer HAS	No Special Laundry Needs	Special Laundry Needs
Washer/Dryer	60	120
Washer/No Dryer	90	180
No Washer or Dryer	120	240

Up to 30 minutes per week may be added if a manual wringer is used.

17. Shopping ... ☐ Preparing shopping list ☐ Going to store and purchasing or picking up items ☐ Picking up medication or DME ☐ Putting food away ☐ Frequency: ☐ Weekly ☐ Monthly ☐ PRN

REVISED 1/1/99

PURPOSE: This form will document work completed for two weeks and will serve as a record for payroll purposes.

PROCEDURE: The consumer or the personal assistant will complete the form by documenting hours worked completing each task as authorized on the plan of care (DPHHS-MA-156). Both the employee and the consumer must sign the form.

DISTRIBUTION: After the form is completed, the white copy is sent to the provider agency. The yellow copy is for the consumer's records.

INSTRUCTIONS: Identifying Information--Complete the identifying information for both the employee and the consumer.

Authorized Hours--Enter the corresponding date with the day of the week. Enter time in and time out for each day and shift worked. Total hours performed for the day. At the end of each week, total hours of service provided.

Task List--Under appropriate day of the week, check the tasks completed. **REMINDER:** Reimbursement will only be made for completing tasks as authorized on the Service Plan.

Comments--Record any pertinent comments.

Home and Community Based Services (HCBS)--Record dates and hours worked as explained under state plan section. Check the appropriate tasks completed.

Under **NO** circumstance will the department pay for HCBS services without the **PRIOR** approval of the case management team.

Signatures--Both employee and consumer must sign and date form. By signing this document, employee and consumer are verifying that the information contained on this form is true and accurate. Misrepresentation constitutes fraud.

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STATE OF MONTANA
Department of Public Health and Human Services

SELF DIRECTED PERSONAL ASSISTANCE SERVICES DELIVERY RECORD

Employee Name	Employee No	City	Pay Period (Mo/Day/Yr)
Consumer Name	Consumer No	City	County

Employees must complete all sections of the service delivery record in order to obtain payment.		Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S
	Date														
	Time In														
	Time Out														
	Total														
STATE PLAN (Check Tasks As Completed)		Weekly Total ➸							Weekly Total ➸						
Bed Bath, Shower, Tub															
Dressing Assistance															
Exercise															
Grooming															
Toileting															
Transfer Assistance															
Ambulation Assistance															
Meal Preparation															
Eating Assistance															
Bowel Program															
Wound Care															
Urinary Systems Management															
Medication Administration															
Escort															
Household Tasks															
Laundry															
Shopping															

Comments:

All services under HCBS must be pre-approved by the case management team.															
	Date														
	Time In														
	Time Out														
	Total														
HCBS Tasks		Weekly Total ➸							Weekly Total ➸						
Supervision / Socialization															
Extended State Plan															
Social Escort/Transportation															

This is to certify that I worked the hours recorded and completed the work tasks assigned.

Employee Signature ________ Date ________

This is to certify that to the employee has worked the hours recorded, completed the tasks assigned. Misrepresentation constitutes fraud.

Consumer/PR Signature ________ Date ________

Department of Public Health and Human Services	SECTION: APPENDIX
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Consumer Agreement (DPHHS-MA-159)

PURPOSE: This form will document the consumer's acceptance of their responsibilities under the Self-Directed Personal Assistance Program.

PROCEDURE: The consumer and a witness must sign and date this form prior to starting services. A witness may not be an individual who will be working for the consumer.

DISTRIBUTION: After completing, the white copy is sent to the provider agency, the yellow copy is for the consumer's record and the pink copy should be forwarded to the health care professional.

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STATE OF MONTANA
Department of Public Health and Human Services

Self-Directed Personal Assistance Services Program
Consumer Agreement

The Self-Directed Personal Assistance program is the result of legislation developed by the Montana Coalition Concerned with Disabilities. This program will allow a consumer with a disability or their personal representative, to arrange for, train and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act. The exemption will allow you the opportunity to manage specific health maintenance tasks with the approval of a health care professional. These tasks may include urinary system management, bowel treatments, administration of medication and wound care.

To participate in this program, as the consumer you are responsible for the following:

1. Obtaining approval from your physician or a health care professional to participate. Under this program, a health care professional is defined as a physician assistant certified, nurse practitioner, registered nurse, occupational therapist, or a medical social worker as a member of a case management team for the purposes of the Home and Community Based Services program.

2. Obtaining approval from the health care professional to manage health related tasks. This approval may be limited or include the full scope of the task. For any health related tasks authorized by the health care professional, access to Medicaid Home Health services will be limited.

3. Select a provider in your area that you wish to work with. This provider will become the employer of record for your attendant, assist with the necessary paper work and act as a liaison with the Department.

4. Develop a service plan which includes:
   a) a consumer profile completed by the provider to establish the service limit in terms of hours;
   b) an emergency back up plan which addresses the process you will follow when your attendant fails to show. Your back up plan may not be Medicaid Personal Assistance Services managed by an agency or home health services for authorized health maintenance tasks. These services become available to you only when and if your emergency backup plan fails;
   c) a training plan for attendants performing health related tasks, should your physician or health care professional authorize them;
   d) the method you will use to recruit attendants; and
   e) a supervision schedule which is no less than once every 180 days.

5. Recruit, train, schedule and manage all attendants who will provide services. You will also be prepared to resolve any attendant issues which may arise.

(Continued on back)

6. Approve all service delivery records which allow for Medicaid to be billed. **MISREPRESENTATION WITHIN THESE DOCUMENTS CONSTITUTES FRAUD.**

7. Obtaining re-certification for continued participation every 180 days from the provider agency. Obtain annual approval from your health care professional.

8. Participation in compliance reviews conducted by the Department. These reviews are designed to insure that services are being delivered in accordance to the policies of the Department.

9. Medical and related liability regarding the delivery of Personal Assistance Services. According to the statutory language which created this program, you will be responsible for any incidents of harm.

10. Amend your plan of care should you chose to no longer manage health maintenance tasks. As long as it appears on your plan of care, you are unable to access home health agency services for the same activity.

I understand that if I participate in the Self-Directed Personal Assistance program, I must receive the proper authorizations and follow all Medicaid policies and procedures. I understand that my failure to do this can lead to a Medicaid fraud investigation. If I have additional questions regarding the self-directed program, I may contact the local Regional Program Officer with the Senior and Long Term Care Division, Department of Public Health and Human Services.

______________________________ ______________________
Consumer Date

______________________________ ______________________
Witness Date

Department of Public Health and Human Services	SECTION: APPENDIX
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Information for the Health Care Professional (DPHHS-MA-160)

PURPOSE: This form serves as documentation that the health care professional does understand the basics of the Self-Directed Personal Assistance Program.

PROCEDURE: The consumer and health care professional must sign and date this form, prior to starting services. Verbal approval is **NOT** acceptable.

DISTRIBUTION: After completion; the white copy goes to the provider, the yellow copy is for the consumer's records and the pink copy should be retained by the health care professional.

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Self-Directed Personal Assistance
Information for the Health Care Professional

The Self-Directed Personal Assistance program is the result of legislation developed by the Montana Coalition Concerned with Disabilities. This program allows a person with a disability or a personal representative, to arrange for, train, and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act. This exemption allows consumers the opportunity to manage specific health maintenance tasks which in absence of their disability they would be able to safely manage for themselves. These tasks include urinary system management, bowel treatments, administration of medication and wound care.

To participate in this program, the consumer must receive authorization from a health care professional. A health care professional for the purposes of this program can be a physician, physician assistant-certified, nurse practitioner, registered nurse, occupational therapist or a medical social worker as a member of a case management team for the purposes of the Home and Community Based Services program. As a part of the authorization process, the health care professional must indicate in the plan of care which health maintenance tasks can be managed by the consumer. These tasks may be limited or may include the full scope of the task. Health maintenance services which are authorized will not be covered by another Medicaid program such as Home Health, except in cases when the consumer's emergency back up plan fails.

Example:

> The health care professional authorizes bowel treatments to be managed by the consumer who will be training an attendant of their choice to do the task. Skilled nursing services under the Medicaid Home Health program will not be available for this task.

Although the health care professional is authorizing the task, medical and related liability for services provided under this program rests with the individual directing the care. This is either the consumer or a personal representative.

The recipient will be recertified for eligibility every 180 days after admission to the program, and reauthorization from the health care professional is required on a yearly basis. The recipient will notify the health care provider at the time this is needed.

For additional information, contact the local Regional Program Officer with the Senior and Long Term Care Division, Department of Public Health and Human Services.

As a health care professional, I understand my role in the Self-Directed Personal Assistance program. I agree the consumer is capable of managing their health issues and understands the risks involved.

______________________________ ________________
Health Care Professional Date

______________________________ ________________
Consumer Date

Distribution: White-Provider; Yellow-Consumer; Pink-Health Care Professional

Department of Public Health and Human Services	SECTION: APPENDIX
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Personal Assistance Services Forms Requisition

PURPOSE: This form is used to order self-directed personal assistance services forms from the Department.

INSTRUCTIONS: The provider agency fills in the quantity of forms needed for a six month period and mails or faxes the forms requisition to the Department.

All forms come in bundles of 50 but can be requested in smaller quantities. Please **DO NOT** put down number of bundles, use total number of forms. For example: 100 not 2.

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New 1/99

SENIOR & LONG TERM CARE DIVISION

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES FORMS REQUISITION

Send to: Anne McKenzie
Senior & Long Term Care
DPHHS
P.O. Box 4210
Helena, MT 59604-4210
Phone: 406-444-4541
FAX: 406-444-7743

Location Code: 675

Requesting Office Name:		Request Date:
Street Address:	City: Zip:	Telephone No:
Signature of Requestor:		Date Shipped:

Quantity Requested	Quantity Sent	Form Number	Form Name
_______	_______	MA-153	Self-Directed PAS Health Maintenance Report (New 6/96)
_______	_______	MA-156	Self-Directed PAS Plan/Health Care Professional Approval (New 10/95)
_______	_______	MA-157	Self-Directed PAS Consumer Profile (Rev. 1/99)
_______	_______	MA-158	Self-Directed PAS Delivery Record (Rev. 1/99)
_______	_______	MA-159	Self-Directed PAS Consumer Agreement (Rev. 1/99)
_______	_______	MA-160	Self-Directed PAS Information for Health Care Professional (Rev. 1/99)
_______	_______	MA-164	Self-Directed PAS Amendment Form (New 1/99)
_______	_______	MA-166	Self-Directed PAS Personal Representative Agreement (New 1/99)

NOTE: All forms come in bundles of 50 but can be requested in smaller quantities. Please do not put down number of bundles, use total number of forms. For example: 100 not 2. If you do not receive the forms you ordered, please call the above phone number.

Self-Directed forms are limited to **approved** Self-Directed Personal Assistance Services providers.

Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES

SECTION: APPENDIX

SUBJECT: Directory of Case Management Teams

NAME & ADDRESS	STAFF	COUNTIES
Community Medical Center/Rehab HCBS Case Management 2827 Fort Missoula Rd Missoula, MT 59801 Phone: 327-4585 Fax: 327-4567	Jayne Lux, RN Joann Haven, RN Laura Sherry, RN Sue Kirchmyer, RN Kathy Flynn, SW Tim Laskowski, SW Tamara Bradley, SW	Mineral, Missoula, Ravalli
Partners in Home Care 500 N. Higgins, Ste 201 Missoula, MT 59801 Phone: 728-8848 Fax: 549-8970	Marlene Swisher, RN Ruth Cleveland, SW Susan Smith, SW	Mineral, Missoula, Ravalli
Yellowstone City-County Health Dept HCBS Case Management P.O. Box 35033 Billings, MT 59107 Phone: 247-3226 Fax: 247-3202	Ron McKenna, SW Tris Newell, RN Linda Fleischhauer,RN Dee Dee Chiesa, SW Jill Egan, SW Kaye Blair, RN	Big Horn, Carbon, Rosebud, Stillwater, Sweetgrass, Treasure, Yellowstone
Easter Seal HCBS Case Management 4400 Central Ave Great Falls, MT 59405 Phone: 761-3680 Fax: 761-5110	Karla Egan, LPN Tari Barkley, SW Michelle Gill, SW Mickie Anderson, RN Kathy Smith, RN Stu Lekander	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole
District IX HRDC HCBS Case Management 321 E. Main, Ste 300 Bozeman, MT 59715 Phone: 586-3134 Fax: 585-3538	Gena Boehler, RN Rosemary Taylor, SW	Gallatin, Park, Madison, Meagher

NAME & ADDRESS	STAFF	COUNTIES
L&C City-Co Health Dept HCBS Case Management 1930 9th Ave, Ste 207 Helena, MT 59601 Phone: 443-2584 Fax: 447-1665	Jeanne Underhill, RN Kristi Heilman, RN Dana Gibson, SW	Broadwater, Jefferson, Lewis and Clark
Holy Rosary Home Care HCBS Case Management 2905 Main St #2 Miles City, MT 59301 Phone: 232-3810 Fax: 232-7134	Sandy Short, SW Bev Askin, RN	Carter, Custer, Dawson, Fallon, Garfield, Powder River, Prairie, Rosebud, Wibaux
Sidney Health Center HCBS Case Management P.O. Box 1690 Sidney, MT 59270 Phone: 488-2140 Fax: 482-5514	Robin Knaff-Bender, RN Kerry Reitz, SW Saralou O'Brien, RN	Daniels, Dawson, McCone, Richland, Roosevelt, Sheridan, Valley
NW MT Human Resources HCBS Case Management P.O. Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 752-6582	Debbie Reimnitz, RN Sue Pratt, SW Marla Elliot, RN Emilianne Lansdown, SW	Flathead, Lake, Lincoln, Sanders
Spectrum Medical, Inc. HCBS Case Management 523 E. Front, Suite 529 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Kevin Skocilich, SW Georgia Peterson, RN Virginia Mick, RN	Beaverhead, Deer Lodge, Granite, Powell, Silver Bow

Central Montana Medical Center HCBS Case Management P.O. Box 580 Lewistown, MT 59457 Phone: 538-6297 (Kathy) 538-6382 (Tara) Fax: 538-6267	Kathy Hodgeson, RN Tara Taylor, SW	Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Phillips Wheatland
Area II Agency on Aging HCBS Case Management 1504 Fourth Street W Roundup, MT 59072 Phone: 323-1320 Fax: 323-3859	Shawna Anderson, RN Betty Jo Hiermeier,SW	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Mussellshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone
Western Montana AAA HCBS Case Management 110 Main St Ste 5 Polson, MT 59860 Phone: 883-7284 Fax: 883-7363	John Freemole, SW Karen O'Donnell, RN	Lake, Lincoln, Mineral Ravalli, Sanders
Area VIII Agency on Aging HCBS Case Management 501 Bay Drive Great Falls, MT 59404 Phone: 454-6990 Fax: 454-6991	Debra Kenyear, SW Alice Tone, RN	Cascade
Area X Agency on Aging HCBS Case Management 2 W 2nd St Havre, MT 59501 Phone: 265-5464 Fax: 265-3611	Connie LaSalle, RN Chris Long, SW	Hill
Area XI Agency on Aging HCBS Case Management 227 West Front Missoula, MT 59802 Phone: 728-7682 Fax: 728-7687	Barbara Arnold, SW Polson 883-7284 John Freemole, SW Karen O'Donnell, RN	Missoula

Area IV Agency on Aging 201 S Main PO Box 1717 Helena, MT 59624 Phone: 447-1680 Fax: 447-1629	Linda Simmons, SW Ruth Sasser, RN	Broadwater, Gallatin, Jefferson, Lewis & Clark, Meagher, Park

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: APPENDIX SUBJECT: Directory of Regional Program Officers

NAME & ADDRESS	COUNTIES
Kathy Wise 1211 Grand Avenue Billings, MT 59102 Phone: 247-2650 Fax: 245-9437	Big Horn, Carbon, Golden Valley, Mussellshell, Stillwater, Treasure, Wheatland, Yellowstone
Lalla Chadwick 202 South Black Bozeman, MT 59715 Phone: 586-4089 Fax: 587-7863	Gallatin, Madison, Park, Sweetgrass
Jeanette Prodgers 700 Casey Butte, MT 59701 Phone: 496-4989 Fax: 782-8728	Beaverhead, Deer Lodge, Granite, Silver Bow
Sue Howe 218 West Bell, Suite 205 Glendive, MT 59330 Phone: 377-6252 Fax: 365-6927	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone,Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, Wibaux
Nancy Mortag Deljean Wadsworth 1824 10th Avenue South Great Falls, MT 59403 Phone: 453-8902 (Nancy) 453-8975 (Deljean) Fax: 454-6084	Blaine, Cascade, Chouteau, Fergus, Glacier, Hill, Judith Basin, Liberty, Petroleum, Phillips, Pondera, Teton, Toole
Diane English-Castona 3075 North Montana Avenue PO Box 202958 Helena, MT 59604-2958 Phone: 444-1707 Fax: 444-9659	Broadwater, Jefferson, Lewis and Clark, Meagher, Powell, Montana State Hospital Long Term Care Unit

NAME & ADDRESS	COUNTIES
Richard Rough 2282 Highway 93 South P.O. Box 2357 Kalispell, MT 59903-2357 Phone: 755-5420 Fax: 751-5944	Flathead, Lake, Lincoln, Sanders
Amy Gentry Herb Tipton 1610 S 3rd W, Suite 202 Missoula, MT 59801 Phone: 329-5426 (Amy) 329-5429 (Herb) Fax: 329-5490	Mineral, Missoula, Ravalli

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(5) The department shall determine compliance in the following administrative areas:

(a) attendant basic training;

(b) attendant in service training;

(c) nurse licensure;

(d) response to complaints;

(e) maintenance of incident reports;

(f) recipient surveys;

(g) attendant pool; and

(h) development of agency manuals and handouts.

(6) The department may choose to review other areas of the program at its discretion.

(7) The department shall examine 15 cases or 5% of the provider's case load for the purpose of the compliance review.

(8) The provider must meet all standards in 90% of the cases to be considered in compliance. If 90% compliance is not met, the provider will be given the results of the review and a second compliance review will be scheduled.

(9) The provider must meet all standards in 90% of the cases in the second review or it will be subject to department sanctions as provided in ARM 46.12.402 through 46.12.409. (History: Sec. 53-6-101, 53-6-113 and 53-2-201, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1995 MAR p. 1191, Eff. 7/1/95.)

46.12.559 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, DESCRIPTION AND PURPOSE (1) Self-directed personal assistance services are medically necessary in-home services provided to medicaid consumers whose disability functionally limits performing activities of daily living, and who take the responsibility or have a representative to take the responsibility of managing the services. Self-directed personal assistance services are intended to provide control of service delivery to the consumer and to allow the consumer to direct health related tasks.

(2) Consumers will provide their physician or health care professional evidence of ability to manage their personal assistance services.

(a) The scope and detail of the evidence shall be determined by the physician or health care professional.

(3) Consumers who are unable to utilize self-directed personal assistance services may receive services through the personal assistance services program managed by provider agencies under agreement with medicaid. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.559A SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, APPLICATION OF GENERAL PERSONAL CARE RULES (1) The following ARM cites apply to the self-directed personal assistance services program:

(a) ARM 46.12.555(2) through (5), (7) and (8), pertaining to a description of services provided;

(b) ARM 46.12.556(2), (4), (5), (9), (10), (12), (17), (18), (21) and (25), pertaining to requirements, limitations and termination of services;

(c) ARM 46.12.557 pertaining to reimbursement; and

(d) ARM 46.12.558(1), (6) and (9), pertaining to compliance reviews. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.559B SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, CONSUMER REQUIREMENTS (1) To qualify for self-directed personal assistance, the consumer must:

(a) have a medical condition which results in the need for personal assistance services;

(b) be capable of assuming the management responsibilities of assistants or have an immediately involved representative willing to assume this responsibility;

(c) have authorization from a physician or health care professional to participate in the program; and

(d) be capable of making choices about activities of daily living, understand the impact of these choices and assume the responsibility of the choices.

(2) The consumer must be capable of acting as though the personal assistant is their employee for the purposes of selection, management and supervision of the personal assistant, although the personal assistant is the employee of a self-directed personal assistance provider.

(a) The consumer has the primary responsibility in the scheduling, training and supervision of the personal assistant. The consumer has the right to require that a particular assistant discontinue providing services to the consumer.

(b) The consumer may have an immediately involved representative assume some or all of the responsibilities imposed by this rule. An immediately involved representative is a person who is directly involved in the day to day care of the consumer. An immediately involved representative must be available to assume the responsibility of managing the consumer's care, including directing the care as it occurs in the home. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.559C SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, PLAN OF CARE REQUIREMENTS (1) A consumer must develop a service plan and have it approved annually by a physician or health care professional prior to receiving self-directed personal assistance services. The plan must include:

(a) the consumer's need for personal assistance services as documented by the provider agency through completion of the department's personal assistance services consumer profile;

(b) tasks assigned to the personal assistant;

(c) an emergency back-up plan;

(d) a training plan for assistants performing health related tasks;

(e) a method for recruiting personal assistants; and

(f) a schedule to update the consumer profile by the provider agency at least once every 180 days. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.559D SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, PROVIDER REQUIREMENTS (1) Self-directed personal assistance providers have the following responsibilities:

(a) assist consumers to identify resources for personal assistants;

(b) advise the consumer regarding program participation;

(c) determine the amount of services available to the consumer by completing the consumer profile;

(d) re-certify consumer needs every 180 days;

(e) review the plan of care; and

(f) act as the employer of record for personal assistants for the purposes of payroll and federal hiring practices. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.559E SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, GENERAL REQUIREMENTS (1) Health maintenance activities include urinary system management, bowel treatments, administration of medications and wound care.

(2) Self-directed personal assistance providers are limited to businesses organized under the laws of the state of Montana.

(3) Self-directed personal assistance services may only be delivered by an individual who is the employee of a medicaid enrolled provider and who is selected by the consumer or their immediately involved representative.

(4) Personal assistance services managed by provider agencies under agreement with medicaid are not available to individuals participating in the self-directed personal assistance program.

(a) The use of personal assistance services managed by provider agencies may be permissible in the event that the consumer's emergency back up plan fails.

(5) Home health skilled nursing services are not available to consumers for the completion of health maintenance activities which the consumer has been authorized to manage.

(a) The use of home health skilled nursing services may be permissible in the event that the consumer's emergency back up plan fails.

(6) Consumers who have been terminated from the self-directed program may apply for personal assistance services through the medicaid personal assistance services program managed by approved provider agencies. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.559F SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, COMPLIANCE REVIEWS (1) Compliance reviews shall be conducted on the provider by department staff at the provider's premises.

(a) Completion of the compliance review may require participation from the consumer.

(2) The compliance reviews shall be conducted:

(a) on an annual basis; or

(b) at other times, as determined by the department.

(3) The department shall determine compliance in the following areas:

(a) service delivery;

(b) service authorization;

(c) records maintenance;

(d) assistant surveys; and

(e) consumer surveys.

(4) Providers must achieve a 90% compliance rate as provided in ARM 46.12.558.

(5) Providers have two opportunities to achieve a 90% compliance rate or the following may occur:

(a) providers shall be subject to department sanctions as provided in ARM 46.12.402 through 46.12.409. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95.)

46.12.555 PERSONAL CARE, PURPOSE, SERVICES PROVIDED, AND LIMITATIONS (1) Personal care services are medically necessary in-home services provided to medicaid recipients whose health conditions cause them to be functionally limited in performing activities of daily living. Personal care services are intended to prevent or delay institutionalization by providing medically necessary, long-term maintenance or supportive care in the home.

(2) Personal care includes assistance with the following activities:

(a) activities of daily living;

(b) household tasks; and

(c) escort services.

(3) Activities of daily living are limited to bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medication and meal preparation.

(4) Household tasks are limited to housekeeping activities, provided in accordance with the personal care plan and furnished in conjunction with activities of daily living, that are directly related to the recipient's medical needs. Household tasks include only:

(a) cleaning the area used by the recipient;

(b) changing the recipient's bed linens;

(c) doing the recipient's laundry; and

(d) shopping for groceries and household items essential to the health care, nutritional needs, and maintenance of the recipient.

(5) Escort services are provided by a personal care attendant who accompanies the recipient to a medical examination, treatment or for shopping to meet the recipient's essential health care or nutritional needs. Escort services are available to a recipient who requires personal care services enroute or at the destination, when a family member or caregiver is unable to accompany them.

(6) Personal care services may not include any skilled services that require professional medical training unless otherwise permitted under 37-8-103, MCA.

(7) Personal care services may not include services which maintain an entire household or family or which are not medically necessary. Personal care services do not include:

(a) cleaning floors and furniture in areas recipients do not use or occupy;

(b) laundering clothing or bedding recipients do not use;

(c) supervision, respite care, babysitting or visiting;

(d) maintenance of animals unless the animal is a certified service animal specifically trained to meet the safety needs of the recipient; and

(e) home and outside maintenance.

(8) Personal care provided by a member of the recipient's immediate family is not personal care services for the purposes of the medicaid program, and is not eligible for reimbursement.

(a) Immediate family member includes the following:
(i) husband or wife;
(ii) natural parent;
(iii) natural child;
(iv) natural sibling;
(v) adopted child;
(vi) adoptive parent;
(vii) stepparent;
(viii) stepchild;
(ix) step-brother or step-sister;
(x) father-in-law or mother-in-law;
(xi) son-in-law or daughter-in-law;
(xii) brother-in-law or sister-in-law;
(xiii) grandparent;
(xiv) grandchild;
(xv) foster parents; or
(xvi) foster child. (History: Sec. 53-6-113 and 53-6-201 MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141 MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95.)

46.12.556 PERSONAL CARE SERVICES, REQUIREMENTS (1) To qualify for personal care, a person must be medicaid eligible and demonstrate a medical need for personal care.

(2) Personal care services, except for escort services and household tasks, may be provided only in the recipient's home.

(3) Personal care services provided in licensed foster or group homes must be prior authorized by the department. Personal care services may be authorized when the person's medical needs are beyond the scope of services normally provided by programs funding services in foster or group home settings. For example, a person requiring additional assistance because of an acute medical episode or post-hospitalization period may receive personal care services in a foster or group home setting.

(4) Personal care services may not be provided to persons who reside in a hospital or long-term care facility as defined in 50-5-101, MCA, and licensed under 50-5-201, MCA.

(5) The recipient, in order to receive personal care services, must be capable of making choices about activities of daily living, understand the impact of these choices and assume responsibility for the choices or have someone residing within or outside the household willing to assist the recipient in decision making and to direct their activities.

(6) The type and amount of personal care services must be specified in a plan of care which governs delivery of services. The plan of care for a recipient must be approved by a physician and developed by a licensed nurse employed by a provider. The approval of the service plan must be renewed at least annually. The plan of care shall be developed based upon the completion of the department's recipient profile by the provider.

(7) The delivery of personal care services must be supervised by a licensed nurse.

(8) The recipient must agree to accept the provision of personal care services as specified in the plan of care.

(9) Household tasks and escort services must be provided only in conjunction with other personal care services and must be directly related to a recipient's medical needs.

(10) Household tasks may not account for more than 1/3 of the total time allocated per week for personal care services.

(11) Personal care services must be prescribed in writing at least annually by a physician and must be reviewed at least every 180 days by a licensed nurse.

(12) A recipient may receive personal care services through the medicaid home and community based services program for elderly and physically disabled persons or the medicaid home and community based services program for persons with developmental disabilities, in addition to the personal care services provided through these rules.

(13) Personal care providers must be independent contractors for purposes of federal and state wage and hour laws and workers' compensation laws. Personal care providers are limited to businesses incorporated under the laws of the state of Montana. Personal care providers must demonstrate that they are paying workers' compensation and unemployment insurance premiums.

(14) The department will enroll providers who provide the following documentation:

(a) the provider's articles of incorporation;

(b) a written contingency plan, approved by the department, addressing service delivery to clients in the event an agency is unable to deliver services in a timely manner or in the event the agency ceases operation;

(c) general liability insurance with a minimum coverage of $100,000 per person;

(d) motor vehicle liability insurance with a minimum coverage of $100,000 per person;

(e) current unemployment insurance and worker's compensation coverage;

(f) financial solvency, to include the ability to make a projected 4 month payroll; and

(g) a description of the proposed service area which must be defined to include at a minimum coverage of the entire area of at least one county or Indian reservation.

(15) The department may contract with out-of-state agencies to provide personal care services for Montana medicaid recipients living out of state.

(16) Personal care services may only be delivered by a personal care attendant employed by an enrolled medicaid provider that has met the criteria established by the department for the delivery of personal care services.

(17) Personal care services may not be provided to relieve a parent of child caring or other legal responsibilities.

(a) Personal care for disabled children may be appropriate when the parent is unqualified or otherwise unable to provide the personal care and the child is at risk of institutionalization unless the services are provided.

(18) Personal care services must be delivered in the most efficient manner available.

(19) Personal care services are not available to recipients who live in homes which are not safely accessible by normal modes of transportation.

(20) Personal care services may be terminated for any of the following reasons:

(a) the recipient or other persons in the household subjects the personal care attendant to physical or verbal abuse, sexual harassment, exposure to the use of illegal sustances or to threats of physical harm;

(b) the recipient requests termination of services or refuses to accept help;

(c) the environment of the recipient is unsafe for the provision of personal care services;

(d) the recipient's physician requests termination of services;

(e) the recipient no longer has a medical need for personal care services;

(f) the recipient refuses the services of a personal care attendant based solely or partly on the attendant's race, creed, religion, sex, marital status, color, age, handicap or national origin; or

(g) the recipient refuses to accept services in accord with the plan of care.

(21) The department may terminate or reduce personal care services when funding for services is unavailable.

(22) The provider shall give at least 10 days advance notice to a recipient when personal care services are terminated for reasons listed in subsections (20)(d) through (20)(g).

(23) The provider may immediately but temporarily suspend services for the reasons listed in subsections (20)(a) through (20)(c). Following the temporary suspension of services the provider may enter into an agreement with the recipient to ensure that the violations of subsections (20)(a) through (20)(c) do not reoccur. If the recipient fails to abide by the term of the agreement services may be permanently terminated.

(24) The department shall provide written notice to an applicant when personal care services are initially denied to the applicant.

(25) A person may request a fair hearing for any adverse determination made by the department. Fair hearings will be conducted as provided for in ARM 46.2.201, et seq. (History: Sec. 53-2-201 and 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141 MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1980 MAR p. 2979, Eff. 11/29/80; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95.)

46.12.557 PERSONAL CARE SERVICES, REIMBURSEMENT

(1) Personal care services may be provided up to but not more than 40 hours of attendant service per week per recipient as defined by the plan of care. The department may, within its discretion, authorize additional hours in excess of this limit. Any services exceeding this limit must be prior authorized by the department. Prior authorization for excess hours may be authorized if additional assistance is required:

(a) for a period of time not to exceed 3 months and as the result of an acute medical episode;

(b) for a period of time not to exceed 3 months and to prevent institutionalization during the absence of the normal caregiver; or

(c) for a period of time not to exceed 3 months and during a post-hospitalization period.

(2) Reimbursement for personal care services is $2.64 per 15 minute unit of service. The rate is for units of attendant and nurse supervision service.

(a) A unit of attendant service is 15 minutes and means an on-site visit specific to a recipient.

(b) A unit of nurse supervision service is 15 minutes and means an on-site recipient visit and related activity specific to that recipient.

(3) A person retained personally by a recipient to deliver personal care services is not a provider of personal care services for the purposes of this rule and therefore may not be reimbursed for personal care services by the department.

(4) Reimbursement is not available for personal care provided by immediate family members. (History: Sec. 53-2-201 and 53-6-113 MCA; IMP, Sec. 53-6-101 and 53-6-141 MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1980 MAR p. 2979, Eff. 11/29/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95.)

46.12.558 PERSONAL CARE SERVICES, PROVIDER COMPLIANCE

(1) Providers of personal care services shall be subject to compliance reviews to provide assurance to the department that services are being provided within the rules and policy of the program.

(2) Compliance reviews shall be conducted by department staff on the provider's premises.

(3) The reviews shall take place:

(a) on an annual basis;

(b) 90 days after the enrollment of a new provider; and

(c) at other times as determined by the department.

(4) The department shall determine compliance in the following service delivery areas:

(a) response to referrals;

(b) service initiation;

(c) physician orders;

(d) recipient needs intake;

(e) service delivery;

(f) attendant orientation to recipient;

(g) supervisory visits;

(h) service breaks;

(i) prior authorization; and

(j) service termination.

(5) The department shall determine compliance in the following administrative areas:

(a) attendant basic training;

(b) attendant in service training;

(c) nurse licensure;

(d) response to complaints;

(e) maintenance of incident reports;

(f) recipient surveys;

(g) attendant pool; and

(h) development of agency manuals and handouts.

(6) The department may choose to review other areas of the program at its discretion.

(7) The department shall examine 15 cases or 5% of the provider's case load for the purpose of the compliance review.

(8) The provider must meet all standards in 90% of the cases to be considered in compliance. If 90% compliance is not met, the provider will be given the results of the review and a second compliance review will be scheduled.

(9) The provider must meet all standards in 90% of the cases in the second review or it will be subject to department sanctions as provided in ARM 46.12.402 through 46.12.409. (History: Sec. 53-6-101, 53-6-113 and 53-2-201, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1995 MAR p. 1191, Eff. 7/1/95.)

Sub-Chapter 4

Provider Sanctions

<u>46.12.401 GROUNDS FOR SANCTIONING</u> (1) Sanctions may be imposed by the department against a provider of medical assistance, provided under this chapter; Title 46, chapter 12, ARM 46.12.309, 46.12.4101 and 46.12.4102; Title 46, chapter 17, and Title 46, chapter 25, for any one or more of the following reasons:

(a) Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

(b) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled under the rules of the department.

(c) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(d) Failure to maintain and retain records required by the rules of the department.

(e) Failure to disclose or make available required records to the department, its authorized agent or other legally authorized persons, organizations, or governmental entities.

(f) Failure to provide and maintain services to medicaid recipients at a quality that is within accepted medical community standards as adjudged by a body of peers.

(g) Engaging in a course of conduct or performing an act which the department's rules or the decision of the applicable professional peer review committee, or licensing board, have determined to be improper or abusive of the Montana medicaid program; or continuing such conduct following notification that the conduct should cease.

(h) Breach of the terms of the provider contract or failure to comply with the terms of the provider certification on medical assistance claim forms or the failure to comply with requirements imposed by the rules of the department.

(i) Over-utilizing the Montana medicaid program by inducing, or otherwise causing a recipient to receive services or goods not medically necessary.

(j) Rebating or accepting a fee or portion of a fee or charge for a medicaid patient referral.

(k) Violating any provision of the state medicaid law, Title 53, chapter 6, MCA or any rule promulgated pursuant thereto, or violating any provision of Title XIX of the Social Security Act or any regulation promulgated pursuant thereto.

(l) Submission of a false or fraudulent application for provider status.

(m) Violations of any statutes, regulations or code of ethics governing the conduct of occupations or professions or regulated industries.

(n) Conviction of a criminal offense relating to medical assistance programs administered by the department or provided under contract with the state; or conviction for negligent practice resulting in death or injury to patients.

(o) Failure to meet requirements of state or federal law for participation (e.g. licensure).

(p) Exclusion from the medicare program (Title XVIII of the Social Security Act) because of fraudulent or abusive practices.

(q) Charging medicaid recipients for amounts over and above the amounts paid by the department for services rendered, except as specifically allowed under ARM 46.17.119 and 46.17.121.

(r) Refusal to execute a new provider agreement when requested to do so.

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(s) Failure to correct deficiencies as defined by the ARM or federal regulation after receiving written notice of these deficiencies from the department, or the department of health and environmental sciences or the federal department of health and human services. The standards set forth at 42 CFR Part 442 and the amendments proposed to this section as published in the federal register, vol. 52, no. 126 on July 1, 1987, at page 24752 et. seq. which identify deficiencies for providers of long term care facility services, are hereby incorporated by reference. A copy of 42 CFR Part 442 and the amendments proposed to this section as published in the federal register, vol. 52, no. 126 on July 1, 1987, at page 24752 et. seq. are available from the Department of Social and Rehabilitation Services, Economic Assistance Division, P.O. Box 4210, Helena, Montana 59620-4210.

(t) Formal reprimand or censure by an association of the provider's peers for unethical practices.

(u) Suspension or termination from participation in another government medical program including but not limited to workers' compensation, crippled children's services, rehabilitation services and medicare.

(v) Filing of criminal indictment, information or complaint for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(w) Civil judgement for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(x) Failure to repay or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments.

(y) Threatening, intimidating or harassing patients or their relatives in an attempt to influence reimbursement rates or affect the outcome of disputes between the provider and the department.

(z) Submitting claims for reimbursement of costs or services which the provider knows or has reason to know are not reimbursable. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113 MCA; IMP, Sec. 53-2-306, 53-2-801, 53-2-803, 53-4-112, 53-6-111 and 53-6-131 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1986 MAR p. 1321, Eff. 8/1/86; AMD, 1987 MAR p. 2164, Eff. 11/28/87; AMD, 1989 MAR p. 835, Eff. 6/30/89.)

46.12.402 SANCTIONS (1) The following sanctions may be invoked against providers based on the grounds specified in ARM 46.12.401:

(a) Termination from participation in the medical assistance program.

(b) Suspension of participation in the medical assistance program.

(c) Suspension or withholding of payments to a provider.

(d) Shortening of an existing provider agreement as permitted by the terms of such agreement.

(e) Required attendance at provider education sessions, the cost of which shall not be reimbursed by the department or any of its programs.

(f) Required prior authorization for provision of services.

(g) One-hundred percent review of the provider's claims prior to payment.

(h) Referral to the department of revenue for any action deemed necessary.

(i) In addition to the sanctions listed above, long term care facilities shall be subject to termination of participation when the deficiencies resulting from failure to meet conditions or standards of participation pose immediate jeopardy or the denial of payments for new admissions if the facility's deficiencies resulting from failure to meet conditions or standards of participation do not pose immediate jeopardy. Federal laws regarding termination from participation and intermediate sanctions provided in 42 U.S.C. 1396a(i), 42 CFR 442.2, and 42 CFR 442.117 through 442.119 are hereby incorporated by reference. A copy of 42 U.S.C. 1396a(i), 42 CFR 442.2, and 42 CFR 442.117 through 442.119 may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59620; or

(j) Notification to the public of sanctions taken against a provider. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113 MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87.)

46.12.403 FACTORS GOVERNING IMPOSITION OF SANCTION

(1) The decision to impose sanctions and which sanctions to impose shall be within the discretion of the department except as provided in subsection (3).

(2) The following factors shall be considered in determining the sanction(s) to be imposed:

(a) seriousness of the offense(s);

(b) extent of violations;

(c) history of prior violations;

(d) prior imposition of sanctions;

(e) prior provision of provider education;

(f) provider willingness to comply with program rules;

(g) whether a lesser sanction will be sufficient to remedy the problem;

(h) actions taken or recommended by peer review groups or licensing boards.

(3) Where a provider has been found by a court of competent jurisdiction in either a civil or criminal proceeding to have defrauded the Montana medical assistance program, or has been previously suspended due to program abuse, or has been terminated from the medicare program for fraud or abuse, the department may terminate the provider from the medical assistance program. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113 MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84.)

46.12.404 SCOPE OF SANCTION (1) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due consideration to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to an affiliate where such conduct was accomplished within the course of the affiliate's official duty or was effectuated by the provider with the knowledge or approval of the affiliate.

(2) Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the department or its fiscal agents for any services or supplies provided to persons eligible for the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to thirty (30) days after the date of termination to allow for the transfer of recipients.

(3) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the department or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to thirty (30) days after the date of termination to allow for the transfer of recipients.

(4) When the provisions of subsection (3) of this rule are violated by a provider of services which is a clinic, group, corporation, the department may suspend or terminate such organization and/or any individual person within said organization who is responsible for such violation. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113 MCA;

IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87.)

46.12.405 NOTICE OF SANCTION (1) When a provider has been suspended or terminated, the department shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed. (History: Sec. 53-6-111 MCA; IMP, Sec. 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80.)

46.12.406 PROVIDER EDUCATION (1) Except where termination has been imposed, the department may in its discretion direct each provider, who has been sanctioned, to participate in a provider education program as a condition of continued medicaid participation.

(2) Provider education programs may include any of the following at the discretion of the department:

(a) instruction in claim form completion;

(b) instruction on the use and format of provider manuals;

(c) instruction on the use of procedure codes;

(d) instruction on statutes and regulations governing the Montana medicaid program;

(e) instruction on reimbursement rates;

(f) instructions on how to inquire about coding or billing problems;

(g) any other matter as determined by the department. (History: Sec. 53-6-111 MCA; IMP, Sec. 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80.)

46.12.407 NOTICE OF VIOLATION Should the department have information which indicates a provider may have submitted bills and/or has been practicing in a manner inconsistent with program requirements, and/or may have received payment to which he may not be properly entitled, the department shall notify the provider of the discrepancies noted. The notification shall set forth:

(1) the nature of the discrepancies or violations;

(2) the dollar value of such discrepancies or violations, if known;

(3) the method of computing such dollar value, if applicable;

(4) explanation of further actions to be taken or sanctions to be imposed by the department;

(5) explanation of any actions required of the provider;

(6) the provider's right to a fair hearing. (History: Sec. 53-6-111 MCA; IMP, Sec. 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80.)

46.12.408 SUSPENSION OR WITHHOLDING OF PAYMENTS PENDING FINAL DETERMINATION (1) Where the department has notified a provider of a violation or an overpayment pursuant to ARM 46.12.407 the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payments pending a final determination.

(2) Where the department intends to withhold or suspend payments it shall notify the provider in writing and shall include a statement of the provider's right to request formal review of such decision.

(3) Where the department has terminated or suspended a provider, the provider shall be eligible to bill for covered services for the period covered by the suspension or termination if an appeal is decided in the provider's favor. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113 MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111 MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84.)

46.12.409 FAIR HEARING PROCEDURES (1) A provider who is aggrieved by an adverse action of the department shall be afforded an opportunity for a hearing as provided in this subchapter.

(a) A request for a fair hearing must be in writing and shall be mailed or delivered to the Department of Social and Rehabilitation Services, Hearings Officer, P.O. Box 4210, 111 Sanders, Helena, Montana, 59604.

(b) The request shall be signed by the provider or his designee.

(c) The fair hearing request must be postmarked or delivered to the department not later than the 30th calendar day following the date of notice of the department's written determination.

(d) The fair hearing request shall identify the objections to the department's action, give the reasons for the disagreement, and furnish substantiating materials and information.

(e) The hearings officer will conduct the fair hearing and may hold a pre-hearing conference or require an administrative review, if requested by any party, as provided in ARM 46.2.208, and grant extensions of time as he deems necessary.

(f) The hearings officer will render a written proposed decision within thirty calendar days of final submission of the matter to him.

(2) In the event the provider or department disagrees with the hearing officer's proposed decision, opportunity for appeal is provided in accordance with ARM 46.2.211. (History: Sec. 53-2-201, 53-6-108 and 53-6-113 MCA; IMP, Sec. 53-6-106, 53-6-107, 53-6-111, 53-6-141 and 53-2-201 MCA; NEW, 1984 MAR p. 1639, Eff. 11/16/84.)

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: APPENDIX SUBJECT: Directory of Self-Directed Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Home Care/Fallon Medical Complex Frances Zachman 202 S. 4th St. W. P.O. Box 820 Baker, MT 59313	Phone: 778-2824 Fax: 778-3436	Carter, Fallon, Wibaux
LIFTT Pat Lockwood 929 Broadwater Sq Billings MT 59101	Phone: 259-5181 Fax: 259-5259	Custer, Dawson, Yellowstone
Western Medical Services Jan Hawley 705 Lincoln Lane Billings, MT 59105	Phone: 245-6356 Fax: 245-1224	Yellowstone, Bighorn, Carbon, Musselshell, Stillwater
North Central Independent Living Center Sharlo LaFountain 1120 25th Ave NE Black Eagle, MT 59414	Phone: 452-9834 Fax: 453-3940	Cascade
Home Care Services Donna Findlay 321 E Main, Ste 333 Bozeman, MT 59715	Phone: 582-1680 Fax: 582-1569	Beaverhead, Big Horn, Broadwater, Carbon, Gallatin, Golden Valley, Jefferson, Madison, Mineral, Missoula, Park, Ravalli, Sanders, Stillwater, Sweetgrass, Treasure, Yellowstone, Northern Cheyenne Reservation

PROVIDER	PHONE NUMBER	COUNTIES
Hi-Line Home Programs, Inc. Rick Thompson 90 Highway 2 East Glasgow, MT 59230	Phone: 228-9431 Fax: 228-2984	Custer, Richland, Valley
Caring Hands Home Care Services Bonnie Pratt 503 1st Ave N, Ste 401 Great Falls, MT 59401	Phone: 454-9099 Fax: 454-3261	Cascade
Spectrum Medical Inc Terry Preite 2526 12th Ave S Great Falls, MT 59405	Phone: 800-870-9322 727-9322 Fax: 771-8337	Cascade, Choteau, Deer Lodge, Hill, Lewis & Clark, Pondera, Powell, Silver Bow, Teton
MT Independent Living Project Les Clark 1900 N Main PO Box 5415 Helena MT 59604	Phone: 442-5755 Fax: 442-1612	Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis & Clark, Madison, Meagher, Park, Powell, Silver Bow, Sweetgrass, Wheatland
Western Medical Services Kris Carlson 1117 S Main Kalispell, MT 59901	Phone: 755-4968 Fax: 752-5157	Kalispell - Flathead, Glacier, Lake, Lincoln, Sanders
Express Personnel Service Duyen Cornell 30 E Washington Kalispell, MT 59901	Phone: 257-2255 Fax: 257-5042	Flathead
Libby Home Health Care Joann Croucher 308 East Third Street Libby, MT 59923	Phone: 293-3834 Fax: 293-5877	Lincoln

PROVIDER	PHONE NUMBER	COUNTIES
Express Personnel Service Jay Olson 3709 Brooks Missoula, MT 59801	Phone: 542-0323 Fax: 543-7288	Missoula
Nightingale Nursing Bill Woody 110 South Ave W Missoula, MT 59801	Phone: 541-1700 Fax: 541-1703	Statewide
Summit ILC Mike Mayer 700 SW Higgins Ave Ste 101 Missoula, MT 59803	Phone: 728-1630 Fax: 728-1632	Missoula
Home Caregivers Kathy Skates 108 Jette Trail PO Box 747 Polson, MT 59860	Phone: 883-3590 Fax: 883-3590	Lake, Lincoln

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Subchapter 3

Provider Requirements

46.12.301 PROVIDER PARTICIPATION (1) As a condition of participation in the Montana medicaid program all providers must comply with all applicable state and federal statutes, rules and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the medicaid program and all applicable Montana statutes and rules governing licensure and certification. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

46.12.302 PROVIDER ENROLLMENT AND AGREEMENTS

(1) Providers must enroll in the Montana medicaid program for each category of services to be provided. As a condition of granting enrollment approval or of allowing continuing enrollment, the department may require the provider to:

(a) complete and submit an enrollment application or form;

(b) complete and submit agreements or other forms applicable to the provider's category of service;

(c) provide information and documentation regarding ownership and control of the provider entity and regarding the provider's ownership interest or control rights in other providers that bill medicaid;

(d) provide information and documentation regarding:

(i) any sanctions, suspensions, exclusions or civil monetary penalties imposed by the medicare program, any state medicaid program or other federal program against the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider; and

(ii) any criminal charges brought against and any criminal convictions of the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider related to that person's or entity's involvement in medicare, medicaid or the Title XX services program; and

(e) submit documentation and information demonstrating compliance with participation requirements applicable to the provider's category of service.

(2) Providers shall provide the department's fiscal agent with 30 days advance written notice of any change in the provider's name, address, tax identification number, group practice arrangement, business organization or ownership.

(a) An enrolled provider is not entitled to change retroactively the category of service for which the provider is enrolled, but must enroll prospectively in the new program category. The change in service category will be effective only upon approval of a completed enrollment application for the new service category and on or after the effective date of all required licenses and certifications. The change will apply only to services provided on or after the effective date of the enrollment change.

(3) Except as provided in (2)(a), an approved enrollment is effective on the later of:

(a) one year prior to the date the completed enrollment application is received by the department's fiscal agent; or

(b) the date as of which all required licenses and certifications are effective.

(4) Providers, whose services are covered by the Title XVIII program (medicare), shall meet the certification standards of medicare except as provided otherwise in these rules.

(5) Providers shall render services to an eligible medicaid recipient in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations.

(a) No provider may deny services to any recipient because of the recipient's inability to pay a copayment in ARM 46.12.204 or in ARM 46.17.121.

(6) Providers shall not discriminate illegally in the provision of service to eligible medicaid recipients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), The Age Discrimination Act of 1975 (42 USC 6101, et seq.), The Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended and all regulations and rules implementing the statutes. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1987 MAR p. 900, Eff. 6/30/87; AMD, 1987 MAR p. 1116, Eff. 7/17/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

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<u>46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT</u> (1) Providers must submit clean claims to medicaid within the latest of:

(a) 12 months from the latest of:

(i) the date of service;

(ii) the date retroactive eligibility is determined; or

(iii) the date disability was determined;

(b) 6 months from the date on the medicare explanation of benefits approving the service, if the medicare claim was timely filed and the recipient was medicare eligible at the time the medicare claim was filed; or

(c) 6 months from the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in (1)(a) and (b).

(2) For purposes of this section:

(a) "Clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service;

(b) For inpatient hospital services, date of service is the date of discharge;

(c) The date of submission to the medicaid program is the date the claim is stamped "received" by the department or its designee; and

(d) The claim submission deadline specified in (1) applies regardless of whether or not a third party has allowed or denied a provider's claim. If a third party has not allowed or denied a provider's claim, the provider may submit a claim to medicaid according to the requirements of ARM 46.12.304(6)(c) and subject to the claim submission deadline specified in (1).

(3) Claims must be submitted in accordance with this rule to be valid. In processing claims, the department or its agent may deny payment of or pend a claim upon determining that a basis exists for denial of payment or pending the claim. No further review or processing of a denied claim is required until resubmission of the claim by the provider. The department or its agent is not required to list or identify all possible grounds for denial or pending of the claim. The fact that a particular basis for denial or pending of a claim for a service or item was not identified on an earlier statement of remittance or other similar statement does not preclude denial or pending of the claim on that basis on a later submission of the claim.

(4) Except as provided in (7) of this rule, all medicaid claims submitted to the department are to be submitted on a state claim form which is:

(a) personally signed by that provider;

(b) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization; or

(c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(5) All medicaid claims submitted to the department by a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be submitted on a state claim form which is:

(a) personally signed by the physician provider;

(b) personally signed by a person who has actual written authority to bind and represent the physician provider for this purpose. The department may require a provider to furnish this written authorization; or

(c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(6) The department may require a hospital provider to obtain on the claim form the signature of a physician providing services for which fees are relinquished to the hospital.

(7) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.

(8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under (b) above.

(a) Electrodiagnostic procedures include echocardiology studies, electroencephalography studies, electrocardiology studies, evoked potential studies, holter monitors, telephonic or teletrace checks and pulmonary function tests.

(b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this subsection, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.

(9) If the department pays a claim but subsequently discovers that the provider was not entitled to payment for any reason, the department is entitled to recover the resulting overpayment as provided in (10).

(10) The department is entitled to recover from the provider and the provider is obligated to repay to the department all medicaid payments made to which the provider was not entitled under applicable state and federal laws, regulations and rules. At the option of the department, recoveries may be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment must be made in accordance with ARM 46.12.407.

(a) The department is entitled to recover under (10) any payment to which the provider was not entitled, regardless of whether the payment was the result of department or provider error, or other cause, and without proving that the provider submitted an improper or erroneous claim knowingly, intentionally, or with intent to defraud.

(b) The department is entitled to recover an overpayment from the provider in whose name the erroneous or improper claim was submitted, even if the provider was an employee of another individual or entity and was required as a condition of the provider's employment to turn over all fees received by the provider to the employer.

(11) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service or item provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative, except as provided in these rules. A provider may bill a recipient for the copayments specified in ARM 46.12.204 and 46.17.121 and may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in ARM 46.17.119.

(a) A provider may bill a recipient for noncovered services if the provider has informed the recipient in advance of providing the services that medicaid will not cover the services and that the recipient will be required to pay privately for the services, and if the recipient has agreed to pay privately for the services. For purposes of (11)(a), non-covered services are services that may not be reimbursed for the particular recipient by the Montana medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana medicaid program for the particular recipient if all applicable requirements, including medical necessity, are met.

(b) Except as provided in this rule, a provider may not bill a recipient after medicaid has denied payment for covered services because the services are not medically necessary for the recipient.

(i) A provider may bill a recipient for covered but medically unnecessary services, including services for which medicaid has denied payment for lack of medical necessity, if the provider specifically informed the recipient in advance of providing the services that the services are not considered medically necessary under medicaid criteria, that medicaid will not pay for the services and that the recipient will be required to pay privately for the services, and the recipient has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the recipient indicating that the service will not be paid by medicaid. The provider may not bill the recipient under this exception when the provider has informed the recipient only that medicaid may not pay or where the agreement is contained in a form that the provider routinely requires recipients to sign.

(ii) An ambulance service provider may bill a recipient after medicaid has denied payment for lack of medical necessity.

(c) A provider may not bill a recipient for services as a private pay patient if, prior to provision of the services, the recipient informed the provider of medicaid eligibility, unless, prior to provision of the services, the provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(d) In service settings where the recipient is admitted or accepted as a medicaid recipient by a provider, facility, institution or other entity that arranges provision of services by other or ancillary providers, all other or ancillary providers will be deemed to have accepted the individual as a medicaid recipient and may not bill the recipient for the services unless, prior to provision of services, the particular provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(e) The provider may not bill a recipient for services when medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing or other requirements necessary to obtain payment.

(f) Acceptance of a recipient as a medicaid recipient applies to all services provided by the provider to the recipient, except as provided in (11)(a) or (b). A provider may not accept medicaid payment for some covered services but refuse to accept medicaid for other covered services. Subject to the requirements of ARM 46.12.302(4), a provider may terminate acceptance of medicaid for a recipient in accordance with the provider's professional responsibility, by informing the recipient of the termination and the effect of the termination on provision of and payment for any further services.

(g) If an individual has agreed prior to receipt of services that payment will be made from a source other than medicaid but later is determined retroactively eligible for medicaid, the provider may choose to accept the individual as a medicaid recipient with respect to the services or to seek payment in accordance with the original payment agreement.

(h) A provider that bills medicaid for services rendered will be deemed to have accepted the individual as a medicaid recipient.

(i) Nothing in this rule is intended to permit a provider to refuse to accept an individual as a medicaid recipient where the provider is otherwise required by law to accept an individual as a medicaid recipient.

(12) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

(13) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

(14) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

(15) A government agency may bill the medicaid program for covered medical services under the following circumstances:

(a) The government agency has complied with all federal and state law governing the medicaid program, and assures that the provider has complied with all state and federal law governing the medicaid program, including reimbursement levels.

(b) The government agency accepts assignment from an eligible medicaid provider for services provided prior to eligibility determination. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1981 MAR p. 530, Eff. 5/29/81; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 771, Eff. 7/31/81; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1990 MAR p. 379, Eff. 2/23/90; AMD, 1990 MAR p. 1586, Eff. 8/17/90; AMD, 1992 MAR p. 234, Eff. 2/14/92; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

46.12.304 THIRD PARTY LIABILITY (1) No payment shall be made by the department for any medical service for which there is a known third party who has a legal liability to pay for that medical service except for those services specified in (6) below.

(2) For purposes of this section, the following definitions apply:

(a) A third party is defined as an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the department or a county and includes but is not limited to insurers, health service organizations, and parties liable or who may be liable in tort. Indian health services is not a third party within the meaning of this definition.

(b) A known third party is a third party for which the provider has sufficient information to submit a claim and which if billed for a medical service is likely to pay the claim within a reasonable time.

(c) A potential third party is a third party for which the provider either has insufficient information to submit a claim or which if billed for a medical service, is likely to deny the claim as having no contractual or legal obligation to pay.

(3) For known recipients, the provider shall use its same usual and customary procedures for inquiring about possible third party resources as is done for non-recipients.

(4) If the provider delivers to a recipient or a recipient's legal representative a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.

(a) The words "medicaid has assignment of, or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

(b) If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.

(5) If a provider learns of the existence of a known third party, that provider shall bill the third party prior to billing the department. If the department has knowledge of a known third party and the provider has not complied with (6) or (7) below, the department shall deny payment of the services.

(6) The department shall not deny payment of services solely because of the existence of a third party in the following circumstances:

(a) The primary diagnosis on the claim is for certain prenatal and preventive pediatric care as specified in the medicaid provider manual, copies of which may be obtained from the Montana Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The provider may bill the third party or the department in this circumstance.

(b) The third party is an insurer under a health insurance policy provided by the absent parent of a recipient and that health insurance is obtained or maintained as a result of an enforcement action taken by the child support enforcement division against that absent parent, if the following provisions are met:

(i) the provider submits evidence that the third party has been billed;

(ii) the claim is submitted to the department 30 or more days beyond the date of service and in compliance with the timely filing rules in ARM 46.12.303(1);

(iii) the provider certifies on the claim that notice of payment or denial of the claim has not been received from the third party; and

(iv) the claim is submitted directly to the third party liability unit (hereafter referred to as the TPL unit) within the department.

(c) The provider has billed the third party and has not received a reply from the third party either allowing or denying payment, if the following provisions are met:

(i) the provider submits evidence of the date the third party was billed;

(ii) the claim is submitted 90 or more days beyond the date established in (c)(i) and in compliance with the timely filing rules in ARM 46.12.303(1);

(iii) the provider certifies on the claim that notice of payment or denial has not been received; and

(iv) the provider submits the claim directly to the TPL unit.

(d) The claim is for services for which the department has been granted a waiver from use of the cost avoidance method and the department has chosen to use and continue to use that waiver, as identified in the medicaid provider manual.

(e) The provider is unable to obtain a valid assignment of benefits, if the following provisions are met:

(i) the provider submits documentation that it attempted to obtain assignment;

(ii) the provider certifies on the claim that assignment could not be obtained; and

(iii) the provider submits the claim directly to the TPL unit.

(f) The third party is only a potential third party as defined in (2)(c).

(7) Except as stated in (8), the department shall pay its allowed amount for services, less any known third party payments for those services, for any claim where a known third party exists in the following circumstances:

(a) the claim is submitted under the provisions of (6);

(b) the submitted claim clearly indicates the amount paid by the third party and includes whatever documentation is received regarding the payment from the third party; or

(c) the claim is submitted with a denial document which clearly shows that the third party denied the claim.

(8) For inpatient hospital claims where medicare part A benefits have been paid, the department's sole obligation shall be to pay the medicare part A deductible. For nursing facility service claims where medicare part A benefits have been paid, the department's sole obligation shall be to pay in accordance with ARM 46.12.1226.

(9) In the event the provider receives a payment from a third party after the department has made payment, the provider shall refund to the department, within sixty (60) days of receipt of the third party payment, the lesser of the amount the department paid or the amount of the third party payment.

(a) The refund shall be made payable to Montana medicaid and submitted to the department's fiscal office, and shall indicate the name of the third party payor.

(b) The provider is entitled to retain any third party payments which exceed the medicaid allowed amount if all medicaid payments toward those services have been refunded to the department as required in this subsection.

(10) The department shall make no payment for services in those cases where, if the patient were not a medicaid recipient, the third party payment would constitute full payment with no further obligation owing from the recipient.

(11) For any service where an identified third party has only a potential liability as a tort-feasor, the provider may file a medical lien against that third party. The provider may bill the department prior to determination of liability of the third party if the provider notifies the TPL unit of the identity of the third party and its name and address if known. The provider may keep its lien in place and receive payment from the third party. If payment is received from the third party, the provider must refund to the department as described in (9).

(12) A provider may not refuse to furnish services to a recipient based upon a third party's potential liability for the service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; AMD, 1990 MAR p. 1719, Eff. 8/31/90; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

46.12.305 THIRD PARTY LIABILITY/ATTORNEYS' FEES SCHEDULE IS HEREBY REPEALED (History: Sec. 53-2-201 and 53-2-612, MCA; IMP, Sec. 53-2-612, MCA; NEW, 1980 MAR p. 1610, Eff. 6/13/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; REP, 1990 MAR p. 1609, Eff. 8/17/90.)

46.12.306 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

(3) The department may review the medical necessity of services or items at any time either before or after payment. If the department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements. The department is not precluded by an earlier screening, prior authorization, certification or similar process from reviewing and determining medical necessity of any service or item, or from denying payment or recovering any overpayment based upon any such review or determination. This rule does not require the department to notify a provider or recipient of a medical necessity determination until and unless the department completes its review and takes an adverse action against the provider based upon the determination.

(4) The provider must upon request provide to the department or its designated review organization without charge any records related to services or items provided to a recipient. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

46.12.307 PROVIDER RIGHTS (1) Except as otherwise provided in these rules, a provider may appeal an adverse department action which directly affects the rights or entitlements of the provider under the Montana medicaid program. Appeals are subject to the requirements of ARM Title 46, chapter 2, subchapter 2.

(2) Except as otherwise provided in these rules, a provider may appeal on behalf of an applicant or recipient an adverse department action affecting the applicant's or recipient's eligibility under the Montana medicaid program. Appeals are subject to the requirements of ARM Title 46, chapter 2, subchapter 2.

(3) This rule does not grant to providers any right to notice of actions affecting recipients, including but not limited to eligibility determinations. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

46.12.308 MAINTENANCE OF RECORDS AND AUDITING (1) All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana medicaid recipients which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

(a) In maintaining financial records, providers shall employ generally accepted accounting methods. Generally accepted accounting methods are those approved by the national association of certified public accountants.

(b) The department shall have access to all records so maintained and retained regardless of a provider's continued participation in the program.

(c) In the event of a change of ownership, the original owner must retain all required records unless an alternative method of providing for the retention of records has been established in writing and approved by the department.

(2) In addition to the recipient's medical records, any medicaid information regarding a recipient or applicant is confidential and shall be used solely for purposes related to the administration of the Montana medicaid program. This information shall not be divulged by the provider or his employees, to any person, group, or organization other than those listed below or a department representative without the written consent of the recipient or applicant.

(3) The department, the designated review organization, the legislative auditor, the department of public health and human services, the department of revenue, the medicaid fraud control unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by this rule.

(a) Refusal to permit inspection, evaluation or audit of services shall result in the imposition of provider sanctions in accordance with the rules of the department.

(4) The provisions of this rule specifying the length of time for which records must be retained shall not be construed as a limitation on the period in which the department may recover overpayments or impose sanctions. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97.)

46.12.309 MEDICAL ASSISTANCE MEDICAID PAYMENT

(1) Medicaid will pay only for medical expenses:

(a) incurred by a person eligible for the medicaid program;

(b) for services provided for and to the extent provided for under the medicaid program;

(c) for which third party payment is not available;

(d) not used to meet the incurrment requirement at ARM 46.12.3801 and following rules for persons who are medically needy;

(e) which are not the copayment provided for in ARM 46.12.204; and

(f) to the extent allowed by medicaid. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89.)

46.12.310 STATISTICAL SAMPLING AUDITS (1) At the option of the department, the amount of money erroneously paid to a provider for any given period of time may be determined by the use of statistical sampling and extrapolation, rather than by an audit of 100% of the claims submitted by the provider during the period of time under review. Statistical sampling and extrapolation shall not be used to determine overpayments for inpatient hospital services, outpatient hospital services, or hospital inpatient psychiatric services, or in cases where the number of line items in the review period does not equal 500 or more.

(a) A line item consists of a single service, procedure or item on a medicaid claim form for which a provider has received payment.

(2) If the department chooses to use statistical sampling and extrapolation to determine an overpayment, it will use a statistical method to draw a random sample of claims for the review period and will audit these claims. The department will calculate the provider's error rate based on the net dollar amount overpaid to the provider after any underpayments occurring in the sample have been offset against the overpayments occurring in the sample. The department will then calculate the total overpayment for the review period using an appropriate statistical methodology.

(3) If the department chooses to use statistical sampling and extrapolation, it shall notify the provider of its intention to do so. When the sampling and extrapolation process is completed, the department shall provide the provider with information regarding the sample size, the sample selection method, and the formulas and calculations used in the extrapolation.

(4) It is presumed that the overpayment amount determined by the use of statistical sampling and extrapolation is correct. However, the provider may rebut this presumption by presenting evidence that the sampling and extrapolation process used by the department was invalid, by presenting evidence that claims in the sample determined by the department to be erroneous or overpaid were correctly paid, or by requesting an audit of 100% of the claims paid in the review period, as provided in (5).

(5) A provider who does not agree with the overpayment amount determined by statistical sampling may request that the department conduct a 100% audit of the claims paid in the review period. The request for a 100% audit must be made within 30 days of the date of the notice informing the provider of the results of the statistical sampling. The department must then conduct such a review.

(a) If the audit shows an overpayment amount which is different from the overpayment amount determined by sampling and extrapolation, the amount determined by the audit shall be used by the department in assessing an overpayment against the provider. A provider who disagrees with the results of the audit may appeal by means of the fair hearing procedures set forth in ARM 46.2.202.

(b) The provider must pay the department's costs for such an audit, unless the overpayment amount determined by the 100% audit is at least 10% less than the overpayment amount determined by the statistical sample.

(6) A provider who disagrees with an overpayment determined by statistical sampling and extrapolation may appeal by means of the fair hearing procedures set forth in ARM 46.2.202. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 1993 MAR p. 441, Eff. 3/26/93.)

Rules 11 through 13 reserved

46.12.314 CONTRACTS WITH OTHER AGENCIES (REPEALED) (History: Sec. 53-6-115, MCA; IMP, Sec. 53-6-115, MCA; NEW, 1979 MAR p. 1707, Eff. 12/28/79; REP, 1997 MAR p. 548, Eff. 3/25/97.)

46.12.315 MEDICAL ASSISTANCE, TEMPORARY PROHIBITION OF CERTAIN PROVIDER FEE INCREASES (REPEALED) (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-111 and 53-6-141, MCA; EMERG, NEW, 1977 MAR p. 762, Eff. 10/13/77; AMD, 1977 MAR p. 1250, Eff. 12/23/77; AMD, 1978 MAR p. 213, Eff. 2/25/78; EMERG, AMD, 1979 MAR p. 743, Eff. 7/13/79; AMD, 1979 MAR p. 1124, Eff. 9/28/79; REP, 1988 MAR p. 91, Eff. 1/15/88.)

NEXT PAGE IS 46-1185

Department of Public Health and Human Services	SECTION: APPENDIX
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Amendment Form (DPHHS-MA-164)

PURPOSE: This form is to be used by the provider agency to document a temporary change in a consumer's schedule or to otherwise amend a plan of care. This will eliminate the need to complete a new MA-156 (Plan of Care) each time a change is made. The MA-156 should be completed only at intake and on an annual basis thereafter.

NOTE: A significant change in the plan of care does require a new Consumer Profile (MA-157). A temporary change in the plan of care due to an acute situation does not require a new Consumer Profile.

PROCEDURE: One section of this amendment is to be completed by the provider agency each time there is a change in the original plan of care. There are six sections on this form which will allow documentation of change(s) on six different occasions per form.

DISTRIBUTION: This form is to be kept in the consumer's file. It is not necessary to obtain physician or consumer signatures.

INSTRUCTIONS: Identifying Information--Complete all of the identifying information. The consumer number may be either their Medicaid number or an agency specific number.

State Plan Tasks--List the frequency of **all** tasks to be managed by the consumer, including those which changed and those which have not changed.

HCBS Only--List the frequency of HCBS services to be managed by the consumer. These services, including any change, must be prior authorized by the HCBS Case Management Team.

HEALTH MAINTENANCE: List the frequency of health maintenance tasks to be managed by the consumer.

Weekly Total--Document the weekly total hours authorized for personal assistance tasks (PA), homemaking tasks (HT), and HCBS health maintenance activities (HM).

Comments--Briefly summarize any new pertinent information concerning the consumer, including the reason for the amendment to the plan of care. The individual completing this amendment must date and initial the section at the time of change.

Complete a new section of this form each time there is a change in the original Plan of Care.

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STATE OF MONTANA
Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES AMENDMENT FORM

Recipient Name: ______________________ Recipient No: ____________
Address: ______________________ Phone No: ____________
(Street) (City) (Zip Code)

STATE PLAN TASKS

Frequency	Task	Frequency	Task	Frequency	Task
	Bathing		Ambulate		Shopping
	Dressing		Meal Preparation		Other
	Exercise		Eating	HCBS ONLY	
	Grooming		Escort		Socialization
	Toileting		Household		Supervision
	Transfer		Laundry		Social Transportation
HEALTH MAINTENANCE				WEEKLY TOTALS	
	Bowel Treatment		Urinary Systems	PA	HT
	Wound Care		Med Mgmt	HM	HCBS

Comments:

Date: ____________ Initial: ______

STATE PLAN TASKS

Frequency	Task	Frequency	Task	Frequency	Task
	Bathing		Ambulate		Shopping
	Dressing		Meal Preparation		Other
	Exercise		Eating	HCBS ONLY	
	Grooming		Escort		Socialization
	Toileting		Household		Supervision
	Transfer		Laundry		Social Transportation
HEALTH MAINTENANCE				WEEKLY TOTALS	
	Bowel Treatment		Urinary Systems	PA	HT
	Wound Care		Med Mgmt	HM	HCBS

Comments:

Date: ____________ Initial: ______

STATE PLAN TASKS

Frequency	Task	Frequency	Task	Frequency	Task
	Bathing		Ambulate		Shopping
	Dressing		Meal Preparation		Other
	Exercise		Eating	HCBS ONLY	
	Grooming		Escort		Socialization
	Toileting		Household		Supervision
	Transfer		Laundry		Social Transportation
HEALTH MAINTENANCE				WEEKLY TOTALS	
	Bowel Treatment		Urinary Systems	PA	HT
	Wound Care		Med Mgmt	HM	HCBS

Comments:

Date: ____________ Initial: ______

Continue on reverse side

STATE PLAN TASKS					
Frequency	Task	Frequency	Task	Frequency	Task
	Bathing		Ambulate		Shopping
	Dressing		Meal Preparation		Other
	Exercise		Eating	HCBS ONLY	
	Grooming		Escort		Socialization
	Toileting		Household		Supervision
	Transfer		Laundry		Social Transportation
HEALTH MAINTENANCE				WEEKLY TOTALS	
	Bowel Treatment		Urinary Systems	PA	HT
	Wound Care		Med Mgmt	HM	HCBS

Comments:

Date: ____________ Initial: ________

STATE PLAN TASKS					
Frequency	Task	Frequency	Task	Frequency	Task
	Bathing		Ambulate		Shopping
	Dressing		Meal Preparation		Other
	Exercise		Eating	HCBS ONLY	
	Grooming		Escort		Socialization
	Toileting		Household		Supervision
	Transfer		Laundry		Social Transportation
HEALTH MAINTENANCE				WEEKLY TOTALS	
	Bowel Treatment		Urinary Systems	PA	HT
	Wound Care		Med Mgmt	HM	HCBS

Comments:

Date: ____________ Initial: ________

STATE PLAN TASKS					
Frequency	Task	Frequency	Task	Frequency	Task
	Bathing		Ambulate		Shopping
	Dressing		Meal Preparation		Other
	Exercise		Eating	HCBS ONLY	
	Grooming		Escort		Socialization
	Toileting		Household		Supervision
	Transfer		Laundry		Social Transportation
HEALTH MAINTENANCE				WEEKLY TOTALS	
	Bowel Treatment		Urinary Systems	PA	HT
	Wound Care		Med Mgmt	HM	HCBS

Comments:

Date: ____________ Initial: ________

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX **SUBJECT:** Self-Directed Personal Assistance Services Personal Representative Agreement (DPHHS-MA-166)

PURPOSE: This form will document the personal representative's acceptance of their responsibilities under the Self-Directed Personal Assistance Program.

PROCEDURE: The personal representative and a witness must sign and date this form prior to starting services. A witness may not be an individual who will be working for the consumer.

DISTRIBUTION: After completing, the white copy is sent to the provider agency, the yellow copy is for the consumer's record and the pink copy is for the personal representative.

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DPHHS-MA-166
(New 1/99)

STATE OF MONTANA
Department of Public Health and Human Services

Self-Directed Personal Assistance Services Program
Personal Representative Agreement

The Self-Directed Personal Assistance program is the result of legislation developed by the Montana Coalition Concerned with Disabilities. This program will allows a personal representative of a consumer with a disability, to arrange for, train and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act. The exemption will allow the opportunity to manage specific health maintenance tasks with the approval of a health care professional. These tasks may include urinary system management, bowel treatments, administration of medication and wound care.

To participate in this program, as the personal representative, you are responsible for the following:

1. Obtaining approval from the consumer's physician or a health care professional to participate. Under this program, a health care professional is defined as a physician assistant certified, nurse practitioner, registered nurse, occupational therapist, or a medical social worker as a member of a case management team for the purposes of the Home and Community Based Services program.

2. Obtaining approval from the health care professional to manage health related tasks. This approval may be limited or include the full scope of the task. For any health related tasks authorized by the health care professional, access to Medicaid Home Health services will be limited.

3. Select a provider in your area that you wish to work with. This provider will become the employer of record for your attendants, assist with the necessary paper work and act as a liaison with the Department.

3. Develop a service plan which includes:
    a) a consumer profile completed by the provider to establish the service limit in terms of hours;
    b) an emergency back up plan which addresses the process you will follow when and if an attendant fails to show. The back up plan may not be Medicaid Personal Assistance Services managed by an agency or home health services for authorized health maintenance tasks. These services become available only when and if the emergency backup plan fails;
    c) a training plan for attendants performing health related tasks, should the consumer's physician or health care professional authorize them;
    d) the method you will use to recruit attendants; and
    e) a supervision schedule which is no less than once every 180 days.

4. Recruit, train, schedule and manage all attendants who will provide services. You will also be prepared to resolve any attendant issues which may arise. As the personal representative, I understand that I can not receive payment as an attendant.

(Continued on back)

Distribution: White-Provider; Yellow-Consumer, Pink-Personal Representative

5. Approve all service delivery records which allow for Medicaid to be billed. **MISREPRESENTATION WITHIN THESE DOCUMENTS CONSTITUTES FRAUD.** The personal representative can be held accountable for knowingly approving service delivery records that contain fraudulent information, resulting in over billing Medicaid.

6. Obtaining re-certification for continued participation every 180 days from the provider agency. Obtain annual approval from the health care professional.

7. Participation in compliance reviews conducted by the Department. These reviews are designed to insure that services are being delivered in accordance to the policies of the Department.

8. Medical and related liability regarding the delivery of Personal Assistance Services. According to the statutory language which created this program, you will be responsible for any incidents of harm.

9. Amend the consumer's plan of care should you chose to no longer manage health maintenance tasks. As long as it appears on your plan of care, the consumer is unable to access home health agency services for the same activity.

I understand that if I participate in the Self-Directed Personal Assistance program, I must receive the proper authorizations and follow all Medicaid policies and procedures. I understand that my failure to do this can lead to a Medicaid fraud investigation. If I have additional questions regarding the self-directed program, I may contact the local Regional Program Officer with the Senior and Long Term Care Division, Department of Public Health and Human Services.

_______________________________ Personal Representative

_______________ Date

_______________________________ Witness

_______________ Date

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** APPENDIX
	SUBJECT: HCBS Referral/Amendment Form Personal Assistance Services (DPHHS-MA-138)

PURPOSE: Case management teams use this form to request HCBS personal assistance services or to amend current HCBS personal assistance services. This form is originated by the case management team. Refer to PAS 312 for instructions.

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HCBS REFERRAL/AMENDMENT FORM
PERSONAL ASSISTANCE SERVICES

☐ HCBS Referral	☐ HCBS Amendment	Emergency Referral? ☐ Yes ☐ No

Recipient Name: ________ D.O.B. ________ Age: ____ Sex: M F

Address: ________
(Street) (City) (Zip Code) (Phone No.)

Living Arrangements: ________ Marital Status: ________

Significant Other(s) (include name, address, phone & relationship): ________

Medicaid No: ________ County: ________ Incurment Amount: ________

Month(s) of Medicaid Eligibility: ________

Physician: ________ Address: ________ Phone No.: ________

Medical Diagnoses: ________

Prior Authorization No: ________ PA Dates: ________

	HCBS SERVICES REQUESTED:	SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS
	Socialization/Homemaker								
	Supervision								
	Specialized Trained Attendants								
	Social Transportation								Mileage: ____

Need for services: ________

Comments: ________

Other services in place: ________

Referred to Agency: ________

Referred By: Team: ________ Individual ________

Phone: ________ Date: ________

TO BE COMPLETED BY PERSONAL ASSISTANCE AGENCY

Date referral received: ________ Date of initiation of care: ________

Referral source follow up date: ________

MONTANA MEDICAID PROGRAM

Department of Public Health and Human Services
Laurie Ekanger, Director

Health Policy and Services Division
Nancy Ellery, Administrator

PO Box 202951, 1400 Broadway
Cogswell Building, Room A206
Helena, MT 59620-2951
(406) 444- 4540

May 1999

MISSION STATEMENT

To assure that necessary medical care is available to all eligible low income Montanans.

In order to fulfill its mission, the Medicaid program must:

- **promote the maintenance of good health by program recipients;**
- **assure recipients have access to necessary medical care;**
- **assure that quality of care meets acceptable standards;**
- **promote the appropriate use of services by recipients;**
- **promote the delivery of appropriate care by service providers;**
- **assure that service providers are paid quickly and accurately; and**
- **assure that services are purchased in a cost-effective manner.**

SERVICE DELIVERY COORDINATION

The delivery of services and administrative activities of the Medicaid Program are located primarily within the Health Services and Policy Division. These services are coordinated with many other divisions in the Department of Public Health and Human Services (DPHHS) as well as other state and federal agencies and private providers. Determination of Medicaid eligibility is administered by the DPHHS Division of Child and Family Services through the local County Welfare/Human Services. Eligibility questions should be directed to these offices. Mental health services are administered by the DPHHS Addictive & Mental Disorders Division. Long-term care services are administered by the DPHHS Senior and Long Term Care Division. Utilization review is administered by the DPHHS Quality Assurance Division.

The Division contracts with Consultec, Inc. to enroll Medicaid providers and process Medicaid claims. Consultec's toll free phone number is 1-800-624-3958.

The Division contracts with Unisys to perform much of the administrative oversight for Passport and the HMO Program. Part of their duties include operating a toll free recipient hotline 1-800-362-8312 and a toll free provider hotline 1-800-480-6823.

GENERAL STATEMENT/CO-PAYMENT

Recipients are responsible for paying the co-payment amounts designated by Medicaid. CHILDREN (under age 21), PREGNANT WOMEN, and NURSING HOME RESIDENTS ARE EXEMPT from co-payments. Co-payments MAY NOT be charged for services provided in an emergency or for family planning.

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
1. **Ambulatory Surgical Centers** Bob Wallace 444-7018)	Selected procedures provided on an out-patient basis.	ASC must be licensed and meet Medicare participation standards.	Department fee schedule does not include physician services, ambulance, or major prosthetic appliances.	$1.00 per visit..
2. **Audiology Services** (ARM 46.12.533) Linda Van Diest 444-4066	Hearing aid evaluation only.	Ordered by physician or mid-level practitioner.	Department fee schedule.	$1.00 per service.
3. **Chemical Dependency Treatment Services (Outpatient)** Michelle Gillespie 444-3182	Intensive outpatient, basic outpatient and aftercare services.	-Must be determined appropriate by a Certified Chemical Dependency Counselor. -Limited to individuals under 21 years of age. -Providers must be approved by Dept. Of Corrections and Human Services.	Department fee schedule.	Exempt.
4. **Chiropractic Services** (ARM 46.12.515) Michelle Gillespie 444-3182	Manual manipulation of the spine and limited x-rays.	Limited to individuals under age 21.	Department fee schedule.	Exempt.
5. **CLINICS** **Diagnostic Clinic** (ARM 46.12.570, 571, 573) Randy Bowsher 444-3995	Evaluation services in diagnosis and evaluation centers.	Services cannot exceed amount, duration, and scope of services outside clinic setting.	Department fee schedule.	$1.00 per visit.
Federally Qualified Health Centers (FQHC) (ARM 46.12.1701, 1703, 1705 and 1707) Debra Stipcich 444-4834	Medicaid covered ambulatory services.	Federally deemed clinic receiving or qualified to receive funds under Section 329, 330 or 340 of the Public Health Service Act.	100% of reasonable cost through an all inclusive interim rate and end of period cost settlement.	$2.00 per visit.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
Freestanding Dialysis Clinics (ARM 46.12.1501 and 1505) Debra Stipcich 444-4834	Outpatient maintenance dialysis; training for self dialysis and home dialysis.	Coordinated with Medicare renal disease program; patients must be diagnosed as suffering from chronic ESRD.	All inclusive composite rate for services with a separate fee for drugs.	$2.00 per visit.
Public Health Clinics (ARM 46.12.570, 570 & 573) Linda Van Diest 444-4066	Outpatient physician, nurse specialist, physician assistant, nursing services.		Department fee schedule	$1.00 per visit.
Rural Health Clinics (RHC) (ARM 46.12.1601, 1603, 1605 & 1607) Debra Stipcich 444-4834	Outpatient services not including dental provided by hospital affiliated-Provider Clinic-or free standing-Independent-clinic.	Medicare certified Clinic located in rural area designated a shortage area by HHS; not a rehab or primarily a facility to treat mental diseases.	Provider Clinics-100% of reasonable cost; Independent Clinics-100% of reasonable cost through an all inclusive interim rate not to exceed an annual cap set by HHS	$2.00 per visit.
Mental Health Services *Addictive & Mental Disorders* Randy Poulsen 444-2706 *Montana Communitiy Partners,* Contractor 1-888-599-2233 (recipients) 1-800-926-6636 (providers)	All services medically necessary in the treatment of a specific range of mental illness diagnoses are provided through the Mental Health Access Plan, the state's managed care program, which is operated by Montana Community Partners.	Most services must be pre-authorized. A recipient's first 15 outpatient therapy or medication management sessions do not require authorization..	According to provider's contract with Montana Community Partners.	Exempt.
6. **Dental services**, including denture services provided by denturists (ARM 46.12.601) Michelle Gillespie 444-3182	Services listed in Department rules.	-Extensive dental services, including dentures, must be prior authorized by the Department. -Services provided by a denturist must be prescribed by a dentist	Department fee schedule.	$1.00 per service.
7. **Dietitian Services** Michelle Gillespie 444-3182	Evaluation and treatment by a licensed nutritionist or dietician	Limited to individuals under 21 years of age.	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
8. **Optometric services** (ARM 46.12.901, 902, 905, 911 and 912) Linda Van Diest 444-4066	Services listed in Department rules.	-Eye examination limited to one annually.	Department fee schedule	$1.00 per service
9. **Eyeglasses** (ARM 46.12.901, 902, 905, 911 & 912). Linda Van Diest 444-4066	Services and items listed in Department Rules.	-One pair of eyeglasses every two years for individuals 21 and over, unless there's a significant change in prescription or the individual has had cataract surgery. -Eyeglasses are through Volume Purchasing Contract.	Department fee schedule	$0 for Eyeglasses. $1.00 per dispensing fee.
10. **Family Planning Services** (ARM 46.12.575) Randy Bowsher 444-3995	Family planning services and supplies for individuals of child-bearing age provided by Title X Family Planning Clinics.	-Sterilizations/abortions limited by federal requirements.	Department fee schedule.	Exempt.
11. **Health Maintenance Organizations** (HMOs) Maureen O'Reilly 444-4148	Services and items listed in Department Rules.	Only certain services are managed by the HMO. Limited to certain geographic areas.	Per contract.	Exempt for HMO covered service.
12. **Hearing Aids** (ARM 46.12.540) Linda Van Diest 444-4066	Hearing Aids, repairs, and accessories.	-Ordered by physician or mid-level practitioner. -Prior authorized by the Department. -Hearing evaluation required by audiologist.	Department fee schedule.	$1.00 per service.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
13. **Home and Community Based Services** (HCBS Medicaid Waiver) (ARM 46.12.1401) *Senior & Long Term Care* Cecilia Cowie 444-4150 Annette Marron 444-4142 Claims Resolution	In-home services designed to serve individuals in the community who would otherwise require nursing home or hospital care. Services include case management, homemaker, personal care, respite, adult day care, medical alert, environmental modifications/ adaptive equipment, meals, dietitian, social transportation, habilitation, respiratory therapy, nursing & psychological consultation, adult residential, child care for children with AIDS & special services for individuals with a traumatic brain injury.	-Recipient must meet nursing home or hospital level of care and services must be ordered by a physician. -Medicaid cost of care in community cannot exceed cost of institutional care.	Reimbursement varies by service.	Exempt.
14. **Home Health Services** (ARM 46.12.550) *Senior & Long Term Care* Barbara Smith 444-4064	Intermittent skilled nursing services, home health aide services, physical, occupational & speech therapy services and supplies related to services delivered.	-Ordered by a physician. -Limited to a combined maximum 100 visits per state fiscal year except nursing services which have a limit of 75 visits per recipient per state fiscal year. More nursing visits may be available with prior authorization. -All Home Health Aid services must be prior authorized. -Recipient must be homebound OR cannot readily obtain needed medical services other than through a Home Health Agency. -Recipient receiving PCA services may not receive home health aid services.	Department Fee Schedule	$2.00 per service. $.50 per item for equipment and supplies.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
15. **Home Dialysis Attendant Services** (ARM 46.12.560) *Senior & Long Term Care* Barbara Smith 444-4064	Payment for trained dialysis attendants to assist dialyzing recipients at home.	-Provided only to recipients diagnosed by a physician as suffering from chronic end stage renal disease. -Provided only when there is no family member who can be trained to perform the dialysis. -Attendants must be licensed RN or LPN trained by home dialysis training center.	Department fee schedule	Exempt.
16. **Hospice** (ARM 46.12.1819) *Senior & Long Term Care Div* Barbara Smith 444-4064	Services and terms listed in Department rules.	-All services related to terminal condition to be provided by Hospice except for attending physician, personal care and HCBS waiver.	Federally set rates	Exempt.
17. **Hospital** **In-Patient Hospital Services** (ARM 46.12.503) Jane Bernard 444-2528 Reimbursement and coverage *Quality Assurance Div.* Carol Jorgensen 444-0190 Utilization review	Medically necessary services ordinarily furnished in a hospital, including: -bed and board -nursing and other related services -use of hospital facilities -medical social services -drugs, biologicals, supplies, appliances and equipment -other diagnostic or therapeutic items or services -medical or surgical services provided by interns and residents-in-training	-Limited to medically necessary days, except drug/alcohol detox limited to four days unless condition requiring hospital care -Sterilization/abortions limited by federal requirements. -Acute Care Rehabilitation Units and Psychiatric Units. -Admissions subject to preadmission review by the department's designee or peer review organization. -Transplant services limited to Medicare approved facilities.	Prospective system based on diagnostic related groups (DRGs) for in-state and border hospitals. Cost based for free-standing psychiatric hospitals, distinct part rehabilitation units and out-of-state hospitals	$100.00 per discharge from the hospital.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
Out-Patient Hospital Services (ARM 46.12.506) Jane Bernard 444-2528	Medically necessary preventive , diagnostic, therapeutic, rehabilitive and palliative services.	-Limited to emergency room services and services covered by Medicaid in non-hospital setting and ordered by or under the direction of a physician.	Prospective payment for ER, ambulatory surgery, dialysis, laboratory, imaging and other diagnostic services. Retrospective reimbursement for all other outpatient services, (Rural hospitals & MAFs are not subject to prospective payment.	$1.00 per line item.
19. **In-Patient Rehabilitation (Physical) Services** Jane Bernard 444-2528 Reimbursement & Coverage *Quality Assurance Division* Carol Jorgensen 444-0190 Joan Ashley 444-4121 *Senior & Long Term Care* Kelly Williams 444-4147 Skilled Nursing Facilities Utilization Review *Prior Authorization* Mountain Pacific Quality Health Foundation 443-4020 1-800-262-1545	Medically necessary services provided in the following settings: 1. Medicare certified hospitals; or 2. Medicare certified skilled nursing facility.	-Limited to acute care rehabilitation. -Limited to medically necessary days. -Rehabilitation centers which do not meet Medicare certification specified in "scope" are not covered. -Hospital admissions must be prior authorized by the Department's peer review organization. -Nursing home admissions must be prior authorized by the Department.	Cost-based.	Dependent of type of facility. See hospitals or nursing homes.
20. **Early, Periodic Screening Diagnosis & Treatment (EPSDT)** (ARM 46.12.514, 515, 516) Michelle Gillespie 444-3182	Screening and diagnostic services to determine and treat physical and mental illness or handicap.	Limited to individuals under 21 years of age.	Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
21. **Medical supplies, prosthetic devices, and durable medical equipment** (ARM 46.12.801) Frank Malek 444-4068 Coverage & Reimbursement *Quality Assurance Division* Carol Jorgensen 444-0190 PA for Air Fluidized Beds, Augmentative Communication Devices, Hospital Beds Purchase), Wheelchairs & Items costing $1,000 or more.)	Items listed in Department rules.	-Prior authorization as indicated in ARM. -Ordered by a physician.	Department fee schedule	$.50 per item.
22. **Mid-Level Practitioner Services** (ARM 46.12.2010) Randy Bowsher 444-3995	Limited to services provided within the scope of practice allowed by state law.	Services must be provided: 1. Within the level of physician supervision required by law; 2. Delivery of babies by nurse midwives must be in a licensed facility.	Department fee schedule.	$2.00 per service. (Pregnant women are Exempt.)
23. **Other laboratory and X-ray Services** Randy Bowsher 444-3995	Laboratory and x-ray services performed in a physician's office or in a free-standing facility, including a hospital acting as an independent laboratory. Services may not be provided in a hospital outpatient department or clinic.	Laboratory and radiology services as ordered by a physician, dentist or optometrist.	Department fee schedule, or for laboratory services, 60 percent of the Medicare prevailing whichever is lower.	$2.00 per service in a physician's office.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

S. 'ICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
24. **Out-of-State Services** (ARM 46.12.502) *Quality Assurance Division* Joan Ashley 444-4121 *Prior Authorization* Mountain Pacific Quality Health Foundation 443-4020 1-800-262-1545	All Medicaid Services which are not available in-state or within 100 miles of MT border subject to limitations specified in the next column.	-Out-of-state services are subject to the same limitations of the Montana Medicaid Program as in-state services. -May not go beyond 100 miles of the MT border for services, if the same services are available within that boundary. -Out-of-state services are allowed only when: .there is a medical emergency and the recipients's health would be endangered if he were required to travel to Montana to obtain the medical services; .the recipient travels to another state because the Department finds the required medical services are not available in Montana; or it is determined by the Department that it is general practice of recipients in a particular locality to use medical resources in another state; .the recipient or his representative can demonstrate to the satisfaction of the Department that out-of-state medical services and all related expenses will be less costly than in-state services; or .the recipient is a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments. .Inpatient services subject to preadmission review by the Department's peer review organization or designee.	Determined by type of service.	Amount is dependent on type of service provided. Refer to specific service for co-pay amount.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
25. **Outpatient Drugs** (ARM 46.12.701) Dorothy Poulsen 444-2738 Betty DeVaney 444-3457 Manufacturers Rebate	Drugs approved by FDA and requiring a prescription and over-the-counter drugs which are insulin, asprin, laxatives and antacids.	-Prescribed by licensed practitioner. -Less-than -effective and experimental drugs are not covered. -Specific classes of drugs are limited to formulary products unless PA is obtained.	Maximum allowable cost (MAC) or estimated acquistion cost (EAC) plus dispensing fee.	$1.00 per prescription Generic. $2.00 per prescription brand name.
26. **Home Infusion Therapy** Rule # not yet assigned. Dorothy Poulsen 444-2738	Services listed in Dept. Rules, provided by licensed home infusion therapy providers.	Prescribed by licensed practitioner. Specific theapies as limited by Dept. Rule. May not be provided in a hospital.	Pharmacy - see outpatient drugs. Nursing - Home Health or PDN per Diem - Department fee schedule.	Pharmacy - Exempt Nursing - See Home Health or PDN Per diem $.50 per unit.
27. **Outpatient physical therapy, speech therapy and occupational therapy** (ARM 46.12.525A-46.12.527A) Linda Van Diest 444-4066	Services listed in Department rules.	-Ordered by physician or mid-level practitioner -PT, ST & OT services limited to 70 hours per year without prior authorization by the Department. An additional 30 hours if determined medically necessary by the Department.	Department fee schedule.	$1.00 per hour.
28. **PASSPORT TO HEALTH** Maureen O'Reilly 444-4148	Recipients choose primary care provider who manages their care.	Limited to specific geographic areas of coverage, only certain services will be managed by primary care provider, refer to Department rules.	Department fee schedule.	Same as without PASSPORT.
29. **Personal Assistant Services** (ARM 46.12.555) *Senior & Long Term Care* Barbara Smith 444-4064	In-home services, including assistance with basic personal care functions such as bathing, grooming, dressing, toileting, transferring, walking, meal preparation, feeding, help with self-administered medications, escort to obtain medical care. Some assistance with home management.	-Ordered by physician. -Supervised by licensed nurse at least 180 days. -May not be provided in a long-term care facility, including a licensed personal care facility. -Limited to 40 hours per week.	Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
Self-Directed Personal Assistance Services. (ARM 46.12.555) *Senior & Long Term Care Div.* Barbara Smith 444-4064	Client-directed personal assistance services.	-Ordered by a physician or health care professional.	Department fee schedule.	Exempt.
30. **Physician's Services** (ARM 46.12.1201) Randy Bowsher 444-3995 Fran O'Hara 444-3337 Claims Resolution	Services within the scope of the practice of medicine or osteopathy.	-Sterilizations/abortions limited by federal requirements. -Cosmetic services are not covered unless severe impairment to patient's physical and psycho-social well-being is demonstrated and treatment is prior authorized by the Department. -Treatment of infertility is not covered.	Department fee schedule.	$2.00 per service.
31. **Podiatry Services** (ARM 46.12.521) Randy Bowsher 444-3995	Services listed in Department rules.		Department fee schedule.	$2.00 per service.
32. **Presumptive Eligibility** (ARM 46.12.3401) Wendy Olson 444-4189	Ambulatory prenatal care for a time period of less than two months while formal application for public assistance is being made.	Ambulatory prenatal care (Approved Medicaid Services).	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
33. **Private Duty Nursing Non-Hospital Services** (ARM 46.12.565) Michelle Gillespie 444-3182 Reimbursement & coverage *Quality Assurance Division* Carol Jorgensen 444-0190 Utilization review.	Skilled nursing services outside of a hospital which includes RN and LPN services.	-Ordered by a physician. -Prior authorized by Department. -Recipients must be under 21 years of age or receiving as part of home infusion therapy. -Respite care is not covered.	Department fee schedule.	Exempt, except for home infusion therapy
35. **QDWI (Qualified Disabled & Working Individual)** Wendy Olson 444-4189	Medicaid pays Medicare Part A premiums.			
36. **QMB (Qualified Medicare Beneficiary** Kathy Demme 444-4871	Medicaid pays Medicare premium, co-insurance and deductibles.		Up to Medicaid allowable charge or rate.	Established by service item.
37. **Respiratory Therapy Services** Frank Malek 444-4068	Treatment in the home by a Licensed Respiratory Care Practitioner.	-Ordered by a physician. -Limited to individuals under 21 years of age/	Department fee schedule	Exempt.
38. **School Based Services** Jeff Buska 444-4145	Medical care provided for children in a school setting.	Limited to individuals under age 21.	Department fee schedule.	Exempt.
39. **Skilled and intermediate nursing services in long term care facilities.** *Senior & Long Term Care* Steve Blazina 444-4129	Meal services, medications, nursing and other health services, rehabilitative services, social services and activities programs.	-Ordered by a physician. -Certified by Department for level of care prior to admission/payment.	-Prospective per diem rate, composed of operating, direct nursing and property rates. -Prescription drugs & rehabilitation services (OT, PT, ST) are reimbursed on a fee schedule basis. Other ancillaries are reimbursed at provider acquisition cost.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
40. **Out of State Nursing Homes** (ARM 46.12.1251) *Senior & Long Term Care* Kelly Williams 444-4147	Same as above.	Physician ordered prior approval by Department level of care certified.	Rate established by the State Medicaid agency in the state where facility is located.	Exempt.
41. **Swing Beds** *Senior & Long Term Care* Kelly Williams 444-4147	LTC Services provided in swing beds when no NF beds are available in community & resident meets level of care.	No NF beds available in 25 mile radius of discharging hospital. Must be NF level of care.	Prior calendar year statewide average Medicaid rate for nursing facilities. (NF)	Exempt.
42. **Targeted Case Management** (ARM 46.12.1901-1940) Shari Pettit (HPSD) 444-2574 Pregnant Women Special Health Needs *Disability Determination Division* James Driggers 444-4090 Developmentally Delayed *Addictive & Mental Disorders Div.* Randy Poulsen 444-2706 Adults with Chronic Mental Illness, Severely Emotionally Disturbed Children.	Services designed to assist individuals in accessing needed medical, social, educational and vocational services. The four target groups covered are: -Pregnant women and infants through 1 year of life. -Individuals 16 years of age and older with developmental delays. -Individuals 18 years of age and older with severe mental illness. -Individuals up to 18 years of age with severe emotional disturbance.		Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
44. **Transportation and per diem/Ambulance** (ARM 46.12.1001-1025) Kathy Demme 444-4871 Reimbursement & Coverage Prior Authorization: Mountain Pacific Quality Health Foundation 1-800-292-7114	Ambulance services, air transport, specialized non-emergency transportation services, commercial transportation, mileage and per diem.	-All non-emergency transportation must be prior authorized by MWFMC. -Ambulance must be licensed under state law. -Ambulances are covered for emergency care and for non-emergency care when the patient is stretcher-bound and the ambulance I s ordered by a physician. -Transportation is only covered to obtain medically necessary services from nearest provider. -Transportation is limited to the least expensive means suitable to meet the recipient's needs.	Department fee schedule.	$1.00 per trip Specialized non-emergency.
45. **Indian Health Services** (Sec. 1905B, 1911A of the Social Security Act.) Debra Stipcich 444-4834	Services provided by Indian Health Service Facilities.	Outpatient and Inpatient Services.	Fees set by HCFA annually per visit for outpatient per diem for inpatient.	Exempt.
46. **Health Insurance Premium Payment** *Quality Assurance Div. - TPL* 1-800-457-1978	Group and Individual Health Policies	Health Plan must be determined to be cost effective by TPL prior to reimbursement.	Determined by TPL.	
47. **Medicare Buy-In** *Quality Assurance Div - TPL* Lynn Roberts 444-4552	Payment of Medicare premiums for QMB, SLMB, QDWI and SSI recipients.	Must be eligible for QMB, SLMB, QDWI or SSI related program.	Based on current year's Medicare premium rate as set by SSA.	

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

The provider agency is required to use the following Department forms in providing self-directed personal assistance services. The Department must approve any additional forms developed by the provider agency.

FORM NUMBER	FORM NAME
* DPHHS-MA-128	Request for Case Review
* DPHHS-SLTC-154	Consumer Overview/Referral (Page 1)
* DPHHS-SLTC-158	Agency Discharge Sheet
* DPHHS-SLTC-159	SDPAS Consumer Agreement
* DPHHS-SLTC-160	SDPAS Health Care Professional Authorization
* DPHHS-SLTC-164	SDPAS Oversight Documentation
* DPHHS-SLTC-165	SDPAS Temporary Authorization
* DPHHS-SLTC-166	SDPAS Personal Representative Agreement
DPHHS-SLTC-157	Change in Demographics
DPHHS-SLTC-162	Serious Occurrences Report
	Quarterly Utilization Report
	Provider Prepared Standards

* The Department provides these forms. The other forms are to be copied from the manual by the provider.

INSTRUCTIONS:

The provider agency fills in the quantity of forms needed for a six month period and sends the forms requisition (page 3) to the Department. Please allow two weeks delivery time.

All forms come in bundles of 50 but can be requested in smaller quantities. Please **DO NOT** put down number of bundles, use total number of forms. For example: 100 not 2; 150 not 3.

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Location Code: 675	SELF-DIRECTED PERSONAL ASSISTANCE SERVICES FORMS REQUISITION	Send to: Stephanie Kindt, Senior & Long Term Care, P.O. Box 4210, Helena, MT 59604-4210; Phone: 406-444-4077; FAX: 406-444-7743
Requesting Office Name:		Request Date:
Street Address:	City: Zip:	Telephone No:
Signature of Requestor:		Date Shipped:

Quantity Requested	Quantity Sent	Form Number	Form Name
______	______	MA-128	Request for Case Review (New 4/99)
______	______	SLTC-154	Personal Assistance Services Consumer Overview/Referral - Page 1 (Rev. 7/01)
______	______	SLTC-158	Personal Assistance Services Agency Discharge Sheet (Rev. 5/03)
______	______	SLTC-159	Self-Directed PAS Consumer Agreement (Rev. 2/02)
______	______	SLTC-160	Self-Directed PAS Health Care Professional Authorization (Rev. 1/04)
______	______	SLTC-164	Self-Directed PAS Oversight Documentation (New 7/03)
______	______	SLTC-165	Self-Directed PAS Temporary Authorization (New 8/02)
______	______	SLTC-166	Self-Directed PAS Personal Representative Agreement (Rev. 9/02)

NOTE: All forms come in bundles of 50 but can be requested in smaller quantities. Please do not put down number of bundles, use total number of forms. For example: 100 not 2. If you do not receive the forms you ordered, please call the above phone number.

Self-Directed forms are limited to **approved** Self-Directed Personal Assistance Services providers.

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: FORMS SUBJECT: General Utilization

EVENT	REQUIRED DOCUMENTATION	WHO COMPLETES?
Referral	Consumer Overview/Referral (Page 1)	Referring Source
Intake	Consumer Overview/Referral (Page 1) Profile Authorization Form Service Plan (Page 3)	Foundation Nurse Coordinator Foundation SDPAS/PAS Agency
180th Day Review	PAS Nurse Supervision Documentation SDPAS Oversight Documentation	PAS Agency SDPAS Agency
Annual Review	Consumer Overview/Referral (Pages 1-2) Profile Authorization Form Consumer Overview (Page 3)	Nurse Coordinator Nurse Coordinator Foundation SDPAS/PAS Agency
Change in Condition/ Diagnosis or Request for increase or decrease in hours	Nurse Supervision Documentation SDPAS Oversight Documentation Profile Authorization Form	PAS Agency SDPAS Agency Nurse Coordinator Foundation
Change in Demographics	Demographic Update Form	PAS/SDPAS Agency
Change in Option	Overview/Referral (Page 1)	PAS/SDPAS Agency Same as Intake
Agency Discharge	Agency Discharge Sheet	PAS/SDPAS Agency
Denial of Services	Authorization Form	Foundation

EVENT	REQUIRED DOCUMENTATION	WHO COMPLETES?
Case Conference	Nurse Supervision Documentation SDPAS Oversight Documentation	PAS Agency SDPAS Agency
Every billing period	Utilization Report	PAS/SDPAS Agency
Quarterly	Serious Occurrences Summary Report	PAS/SDPAS Agency Only
Serious Occurrence	Serious Occurrence Report to Regional Program Officers	PAS/SDPAS Agency

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Department of Public Health and Human Services

SELF-DIRECTED

PERSONAL ASSISTANCE SERVICES

SECTION:

FORMS

SUBJECT:

Self-Directed Personal Assistance Services Temporary Authorization (DPHHS-SLTC-165)

PURPOSE: This form is to be used by provider agencies to inform the Foundation and the consumer that temporary Self-Directed Personal Assistance Services have been instituted according to policy for High Risk Referrals or a temporary increase in hours that will exceed 14 days.

PROCEDURE: High Risk- The SDPAS agency evaluates the consumer's immediate needs and the tasks necessary to meet these needs which are then documented on this form. These services should be instituted within 48 hours of receiving the referral and may be continued until the Foundation completes the review and notifies the agency and consumer of their authorization. The Foundation will also assess the capacity of the consumer or personal representative to direct services. After the authorization is received, the agency adjusts the plan accordingly. (Refer to SDPAS 410 or SDPAS 417 for details.)

Change in Profile- When a consumer/PR identifies a change in authorization is needed, the SDPAS agency documents the change in profile that they have implemented as detailed on the Oversight Document. (Refer to SDPAS 410 or SDPAS 417 for details.)

DISTRIBUTION: The SDPAS agency faxes this form to the Foundation on the day the temporary is implemented. The consumer receives the yellow copy and the SDPAS agency retains the white copy.

INSTRUCTIONS: Consumer Information--Enter the name, street address, city, zip code and telephone number of the consumer.

Agency Information--Enter the name, street address, city, zip code and telephone number of the SDPAS agency completing the form.

As of--Enter the date personal assistance services begin.

Personal Representative--If someone other than the consumer will be responsible for the consumer's care, enter name and telephone number.

Plan--List the tasks, hours per day and hours per week that the temporary plan is authorizing.

Schedule--Enter the proposed schedule and the start date for personal assistance services.

Signatures--The consumer/personal representative and the SDPAS agency individual authorizing the temporary services must sign and date the form. Health care professional's signature must be obtained before services can begin via the Health Care Professional Authorization (DPHHS-SLTC-160).

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Department of Public Health and Human Services	SECTION: FORMS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Reserved

Reserved

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Department of Public Health and Human Services	SECTION: FORMS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Oversight Documentation (DPHHS-SLTC-164)

PURPOSE: The self-directed provider agency uses this form to record the content and outcome of specific oversight visits.

To insure that all aspects of oversight visits are performed.

PROCEDURE: This form should be completed with each 180 day evaluation, consumer care conference with other care providers and other situations as needed. It may also be utilized to record information regarding consumer conferences regarding attendant issues or issues with the consumer or personal representative.

Do not use this form to replace charting of consumer concerns, attendant issues or problem solving issues. It is also not to be used as provider agency personnel form.

DISTRIBUTION: The consumer receives the yellow copy and the provider agency retains the white copy for the consumer's file.

INSTRUCTIONS: Consumer's Name--Enter the consumer's full name.

Medicaid ID number--Enter the consumer's Medicaid number.

Personal Representative--Enter the personal representative's name if applicable.

Date of Visit--Enter the date of the visit to the consumer.

Review current overview and profile. Describe current condition and situation--Record what changes in health status or environment have occurred since the previous overview or supervisory visit.

Detail issues requiring resolution--Describe consumer issues that need attention, prioritize based on consumer needs.

Agency action plan--Explain the plan to address the issues that have been identified. If part of the plan is to amend the profile, the last section must also be completed.

Section 2: This section must be completed by the consumer/ personal representative at the 180th day evaluations, optional at other times.

Consumer evaluation of recruitment, training and management of attendants--Ask the consumer to evaluate the attendant's

Consumer's plan for addressing any identified attendant issues--

Section 3: Amendment Request—Check all factors that relate to the need to amend the consumer's profile. Enter date this document is faxed to the Foundation. Enter name, address, phone and reason for new personal representative.

Record the time in and out for this visit. Indicate time elapsed.

Agency Signature--The nurse completing the visit must sign and date this form.

Agency—Enter name of agency and phone number.

Consumer/PR Signature--If the consumer/personal representative is present, they need to sign and date the form. (During case conferences with other providers, it is all right that the consumer is not present.)

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STATE OF MONTANA
Department of Public Health and Human Services

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES OVERSIGHT DOCUMENTATION

☐ Pre-Screen Intake ☐ 180 Day Evaluation ☐ Change in Condition ☐ Conference ☐ Amendment Only ☐ Other:

Current authorization: ________ Average weekly utilization: ________ A temporary increase is in place of ______ hours

Consumer Name: ______________________________ Medicaid ID#: ________________

Personal Rep (if applicable): ______________________________ Date of Visit: ________________

Review current overview and profile. Describe current condition and situation:

Detail issues requiring resolution:

Agency action plan:

Consumer evaluation of recruitment, training and management of attendants (required every 180 days):

Consumer's plan for addressing any identified attendant issues:

Amendment Request needed to correspond with Agency Action Plan
This section must be completed in full and faxed to the Foundation for review. Date Faxed:

				New Personal Representative (PR) Information:
Increase in hours	☐	No change in hours	☐	
Decrease in hours	☐	Change in time per task	☐	Name:
Change in condition	☐	Change in HM tasks	☐	Address:
Change in option	☐	Change in living situation	☐	Phone:
Change in provider	☐	Change in diagnosis	☐	Reason for new PR:
Change in frequency of tasks	☐	Change in PR (detail at right)	☐	

Time In: Time Out: Elapsed Time: Units Billable:

Agency Signature: ______________________________ Agency: ________________ Phone: ____________

Consumer/PR Signature (when available): ______________________________ Date: ____________

Distribution: White-Provider; Yellow-Consumer

Department of Public Health and Human Services	**SECTION:** FORMS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SUBJECT:** Change in Demographics (DPHHS-SLTC-157)

PURPOSE: The Change in Demographics form is used by the provider agency to notify the Foundation of a change in demographics.

PROCEDURE: The Change in Demographics form is completed by the providing agency and faxed to the Foundation.

INSTRUCTIONS: Provider agency needs to copy the form on page 2. The department will not supply the form.

Check whether this change is in the Personal Assistance Services program or the Self-Directed Personal Assistance Services. Enter date faxed to Foundation.

Consumer--Enter the consumer's name, date of birth and Medicaid number.

Demographics--List any changes in demographic information. Leave blank any information that remains unchanged.

Requestor--List name of person completing this form, agency name, telephone and fax numbers.

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DPHHS-SLTC-157
(Rev. 8/02)

STATE OF MONTANA
Department of Public Health and Human Services

CHANGE IN DEMOGRAPHICS

Instructions: Enter name, Medicaid ID number and date of birth.
List changes only and fax to the Mountain Pacific Quality Health Foundation 1-800-268-5767

☐ PAS ☐ SDPAS Date faxed to Foundation: ____________________

Last Name	First Name	Middle Initial	Medicaid ID Number	Date of Birth
Street Address	City		State/Zip/County	Telephone – Home
Mailing Address	City		State/Zip/County	Telephone - Work
Contact Person	Relationship		Telephone – Home	Telephone - Work
Responsible Party	☐ Personal Representative *	☐ Legal Guardian	☐ Other (specify below)	
Street Address	City		State/Zip	Telephone – Home
Mailing Address	City		State/Zip	Telephone – Work

Requested By

Name	Agency	Telephone	Fax

* New personal representatives for the SDPAS program must be screened for capacity.

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: FORMS SUBJECT: Personal Assistance Services Agency Discharge Sheet (DPHHS-SLTC-158)

PURPOSE: The discharge sheet informs the consumer and the Foundation of discharge from the agency's services. This form also provides documentation of discharge for the consumer's agency record.

PROCEDURE: The providing agency completes this form when a consumer is discharged from their services.

DISTRIBUTION: The Agency Discharge Sheet is completed by the providing agency and faxed to the Foundation. The provider agency retains the white for the consumer's file. In all discharges except death, the consumer receives the yellow copy.

INSTRUCTIONS: Consumer Information--Enter the consumer's name, Medicaid number, and date of birth. Enter the date services began and the date of discharge from the agency.

Discharge Code--Circle the reason for discharge. If reason is not listed, explain in #9--"Other".

Consumer requests referral sent to--If the consumer requests services from another agency document the name of this agency and the city.

Narrative--Provide any pertinent information explaining the reason for discharge.

Signature--The person completing the discharge should sign and date the form and enter the agency name.

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DPHHS-SLTC-158
(New 7/00)

STATE OF MONTANA
Department of Public Health and Human Services

PERSONAL ASSISTANCE SERVICES
AGENCY DISCHARGE SHEET

☐ PAS ☐ SDPAS

Consumer Name: ______________________ ______________________
(Last) (First) (MI)

Medicaid Id#: ______________________ Date of Birth: ______________________

Date Service Began (Intake): ______________________ Discharge Date: ______________________

Discharge Code: (Circle One)

1	Death	6*	Moved From Service Area
2	Nursing Home Placement	7*	Agency Not Able to Meet Needs
3	Hospital Placement	8*	Requested Services from Another Agency
4	Medicaid Ineligibility	9	Other (Specify) ______________________
5	Consumer Request		

* Consumer requests referral sent to: ______________________
(Agency) (City)

Narrative: (If necessary)

Signature: ______________________ Date: ______________________

Agency: ______________________

Distribution: White-Agency; Yellow-Consumer

Department of Public Health and Human Services	SECTION: FORMS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Utilization Report

PURPOSE: To assist the Department in budgeting and forecasting to insure the financial viability of the program.

FREQUENCY: This report must be filed 10 days after the completion of a billing period.

If provider bills bi-weekly, an example follows:

July 1 - 14	Due:	July 24
July 15 - 28	Due:	August 7

If provider bills monthly, an example follows:

July	Due:	July 10
August	Due:	August 10

SUBMISSION: Submit Reports to:

Personal Assistance Program
Senior & Long Term Care Division
PO Box 4210
Helena MT 59604

Fax: 406-444-7743

INSTRUCTIONS: Utilization of services:

Complete the Personal Assistance table by entering an accurate number of units of service delivered during each billing period in column (1).

Enter the appropriate unit rate in (2):

a. $3.16 with wage plan;
b. $3.05 without wage plan; or
c. established rate due to negotiated wage plan.

Then multiply by unit rate to obtain cost by service type, record in column (3). Total column (2) and record in the box (4) below.

EXAMPLE:

Billing Period	July 1, 2003 to July 31, 2003		No. of Days	31
	No. of Units (1)	Unit Cost (2)	Cost (3)	
T1019 - Attendant Units	4690	$3.16	$14,820.40	
T1019 TE - Nurse Supervision	378	$3.16	$ 1,194.48	
A0800 - Mileage	900	$ .13	$ 117.00	
Total Cost for Services		(4)	$16,131.80	

A copy of the Utilization Report is on page 3. Copy the report from the manual as the department does not supply this report.

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(Rev. 7/03)

STATE OF MONTANA
Department of Public Health and Human Services

COMMUNITY SERVICES BUREAU UTILIZATION REPORT

Agency:________________________________
Contact Person (please print)________________________
Phone Number:________________ Date Report is Completed:____________

Utilization of services: Complete the following table by providing an accurate number of units of service delivered during each billing period.

Enter total number of units in column (1). Enter the appropriate unit rate (2.). Then multiply by unit rate to obtain cost by service type, record in column (3). Total Column (3) and record in the box (4) below.

PERSONAL ASSISTANCE SERVICES Provider Number: ____________

Billing Period	______ to ______		No. of Days	
	No. of Units (1)	Unit Cost (2)	Cost (3)	
T1019 - Attendant Units		$	$	
T1019 TE - Nurse Supervision		$	$	
A0800 – Mileage		$ .13	$	
Total Cost for PAS		(4)	$	

SELF-DIRECTED PERSONAL ASSISTANCE SERVICES Provider Number: ____________

Billing Period	______ to ______		No. of Days	
	No. of Units (1)	Unit Cost (2)	Cost (3)	
T1019 U9 - Attendant Units		$	$	
T1019 U9 TE - Oversight		$	$	
A0800 - Mileage		$ .13	$	
Total Cost for SDPAS		(4)	$	

Reserved

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Reserved

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Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: FORMS
	SUBJECT: Sample of Personal Assistance Services Delivery Record

Following is a sample of a Personal Assistance Service Delivery Record. The Department does not supply this form.

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STATE OF MONTANA

Department of Public Health and Human Services

PAS 911

PERSONAL ASSISTANCE SERVICES DELIVERY RECORD

Employee Name	Employee No	City	Pay Period (Mo/Day/Yr)

Consumer Name	Consumer No	City	County

		Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S
Employees must complete all sections of the service delivery record in order to obtain payment.	Date														
	Time In														
	Time Out														
	Total														
STATE PLAN (Check Tasks As Completed)		Weekly Total »							Weekly Total »						
Bed Bath, Shower, Tub															
Dressing Assistance															
Exercise															
Grooming															
Toileting															
Transfer Assistance															
Ambulation Assistance															
Meal Preparation															
Eating Assistance															
Bowel Program															
Wound Care															
Urinary Systems Management															
Medication Administration															
Escort															
Household Tasks															
Laundry															
Shopping															

Comments:

		Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S
All services under HCBS must be pre-approved by the case management team.	Date														
	Time In														
	Time Out														
	Total														
HCBS Tasks		Weekly Total »							Weekly Total »						
Supervision / Socialization															
Extended State Plan															
Social Escort/Transportation															

This is to certify that I worked the hours recorded and completed the work tasks assigned.

Employee Signature ______________ Date ______

This is to certify that to the employee has worked the hours recorded, completed the tasks assigned. Misrepresentation constitutes fraud.

Consumer/PR Signature ______________ Date ______

Distribution: White-Provider Agency; Yellow-Consumer

Department of Public Health and Human Services	SECTION: FORMS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Health Care Professional Authorization (DPHHS-SLTC-160)

PURPOSE: This form serves as documentation that the health care professional does understand the basics of the Self-Directed Personal Assistance Program.

PROCEDURE: The consumer completes this form with their most current profile to record what services are authorized.

The consumer and health care professional must sign and date this form prior to starting services. Verbal approval is **NOT** acceptable.

The consumer must have this authorization completed on an annual basis.

DISTRIBUTION: After completion, the white copy goes to the provider, the yellow copy is for the consumer's records and the pink copy should be retained by the health care professional.

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Self-Directed Personal Assistance Services
Health Care Professional Authorization

The self-directed personal assistance program allows a person with a disability (or their personal representative) to arrange for, train, and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act covering urinary system management, bowel treatments, administration of medication and wound care. Montana State Law requires a Health Care Professional to certify, on an annual basis, that the individual is capable of managing their own care, which may include skilled services delivered by non-licensed personnel.

The following plan requires approval by a health care professional. Questions about this plan can be directed to the Personal Assistance Program at the Mountain Pacific Quality Health Foundation at 1-800-268-5767, ext 129 or 130.

Consumer Name:		DOB:	ID#
Personal Representative (if applicable):			
Custodial Tasks: Approved tasks are circled			
Bathing	Dressing	Eating	Medical Escort
Transferring	Positioning	Exercise	Household Tasks
Grooming	Mobility	Med. Reminder	Laundry
Toileting	Meal Prep		Shopping
Health Maintenance Activities: Skilled nursing tasks that are exempted from Nurse Practice for the purpose of this program. Description of activity is provided.			
Medication Administration			
Bowel Treatment			
Urinary Systems Management			
Wound Care			
Total time per week for services:			

I agree that the consumer/personal representative listed above is capable of managing the indicated tasks and they understand the risks involved. I understand that the quality of care delivered rests solely upon the consumer/personal representative. I understand I may revoke this approval at any time.

Health Care Professional Signature ______________________ Date __________

Consumer/Personal Representative Signature ______________________ Date __________

Distribution: White-Provider; Yellow-Consumer; Pink-Health Care Professional

STATE OF MONTANA
Department of Public Health and Human Services

Self-Directed Personal Assistance Services
Health Care Professional Authorization

The self-directed personal assistance program allows a person with a disability (or their personal representative) to arrange for, train, and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act covering urinary system management, bowel treatments, administration of medication and wound care. Montana State Law requires a Health Care Professional to certify, on an annual basis, that the individual is capable of managing their own care, which may include skilled services delivered by non-licensed personnel.

The following plan requires approval by a health care professional. Questions about this plan can be directed to the Personal Assistance Program at the Mountain Pacific Quality Health Foundation at 1-800-268-1145, ext 129 or 123.

Consumer Name:	DOB:	ID#
Personal Representative (if applicable):		

Custodial Tasks: Approved tasks are circled			
Bathing	Dressing	Eating	Medical Escort
Transferring	Positioning	Exercise	Household Tasks
Grooming	Mobility	Med. Reminder	Laundry
Toileting	Meal Prep		Shopping

Health Maintenance Activities: Skilled nursing tasks that are exempted from Nurse Practice for the purpose of this program. Description of activity is provided.		
Medication Administration		Date Added:
Bowel Treatment		
Urinary Systems Management		
Wound Care		
Total time per week for services:		

I agree that the consumer/personal representative listed above is capable of managing the indicated tasks and they understand the risks involved. I understand that the quality of care delivered rests solely upon the consumer/personal representative. I understand I may revoke this approval at any time. 37.40.1301 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, DESCRIPTION AND PURPOSE: (2) Consumers will provide their physician or health care professional evidence of ability to manage their personal assistance services. (a) The scope and detail of the evidence shall be determined by the physician or health care professional.

Health Care Professional Signature _______________ Date _______________

Consumer/Personal Representative Signature _______________ Date _______________

Agency Name _______________ Phone Number _______________

Distribution: White-Provider; Yellow-Consumer; Pink-Health Care Professional

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SECTION: FORMS SUBJECT: Self-Directed Personal Assistance Services Consumer Agreement (DPHHS-SLTC-159)

PURPOSE: This form will document the consumer's acceptance of their responsibilities under the Self-Directed Personal Assistance Program.

PROCEDURE: The consumer and a witness must sign and date this form prior to starting services. A witness may not be an individual who will be working for the consumer.

DISTRIBUTION: After completing, the white copy is sent to the provider agency and the yellow copy is for the consumer's record.

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DPHHS-SLTC-159
(Rev 7/00)

STATE OF MONTANA
Department of Public Health and Human Services

Self-Directed Personal Assistance Services Consumer Agreement

The Self-Directed Personal Assistance program is the result of legislation developed by the Montana Coalition Concerned with Disabilities. This program will allow a consumer with a disability or their personal representative, to arrange for, train and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act. The exemption will allow you the opportunity to manage specific health maintenance tasks with the approval of a health care professional. These tasks may include urinary system management, bowel treatments, administration of medication and wound care.

I understand that if I participate in the Self-Directed Personal Assistance program, I must receive the proper authorizations and follow all Medicaid policies and procedures. I understand that my failure to do this can lead to a Medicaid fraud investigation. If I have additional questions regarding the Self-Directed program, I may contact the local Regional Program Officer with the Senior and Long Term Care Division, Department of Public Health and Human Services.

______________________________	______________
Consumer	Date
______________________________	______________
Witness	Date

To participate in this program, as the consumer you are responsible for the following:

1. Obtaining approval from your physician or a health care professional to participate. Under this program, a health care professional is defined as a physician assistant certified, nurse practitioner, registered nurse, occupational therapist, or a medical social worker as a member of a case management team for the purposes of the Home and Community Based Services program.

2. Obtaining approval from the health care professional to manage health related tasks. This approval may be limited or include the full scope of the task. For any health related tasks authorized by the health care professional, access to Medicaid Home Health services will be limited.

3. Select a provider in your area that you wish to work with. This provider will become the employer of record for your attendant, assist with the necessary paper work and act as a liaison with the Department.

(Continued on back)

4. Develop and maintain a service plan which is readily available in the home. It must include:
   a) a consumer profile completed by the provider to establish the service limit in terms of hours;
   b) an emergency back up plan which addresses the process you will follow when your attendant fails to show. Your back up plan may not be Medicaid Personal Assistance Services managed by an agency or home health services for authorized health maintenance tasks. These services become available to you only when and if your emergency backup plan fails;
   c) a training plan for attendants performing health related tasks, should your physician or health care professional authorize them;
   d) the method you will use to recruit attendants; and
   e) a schedule of oversight visits which is no less than once every 180 days.

5. Recruit, train, schedule and manage all attendants who will provide services. You will also be prepared to resolve any attendant issues which may arise.

6. Review and approve all service delivery records to insure the service plan has been followed, thereby authorizing for Medicaid to be billed. **MISREPRESENTATION WITHIN THESE DOCUMENTS CONSTITUTES FRAUD.**

7. Obtaining re-certification for continued participation every 180 days from the provider agency. Obtain annual approval from your health care professional.

8. Participation in compliance reviews conducted by the Department. These reviews are designed to insure that services are being delivered in accordance to the policies of the Department. This may include a review of home records.

9. Medical and related liability regarding the delivery of Personal Assistance Services. According to the statutory language which created this program, you will be responsible for any incidents of harm.

10. Amend your plan of care should you choose to no longer manage health maintenance tasks. As long as it appears on your plan of care, you are unable to access home health agency services for the same activity.

Department of Public Health and Human Services	SECTION: FORMS
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Personal Representative Agreement (DPHHS-SLTC-166)

PURPOSE: This form will document the personal representative's acceptance of their responsibilities under the Self-Directed Personal Assistance Program.

PROCEDURE: The personal representative and a witness must sign and date this form prior to starting services. A witness may not be an individual who will be working for the consumer.

DISTRIBUTION: After completing, the white copy is sent to the provider agency, the yellow copy is for the consumer's record and the pink copy is for the personal representative.

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DPHHS-SLTC-166
(Rev 7/00)

STATE OF MONTANA
Department of Public Health and Human Services

Self-Directed Personal Assistance Services
Personal Representative Agreement

The Self-Directed Personal Assistance program is the result of legislation developed by the Montana Coalition Concerned with Disabilities. This program allows a personal representative of a consumer with a disability, to arrange for, train and manage the personal assistant(s). This program also includes a limited exemption from the Nurse Practice Act. The exemption will allow the opportunity to manage specific health maintenance tasks with the approval of a health care professional. These tasks may include urinary system management, bowel treatments, administration of medication and wound care.

I understand that if I participate in the Self-Directed Personal Assistance program, I must receive the proper authorizations and follow all Medicaid policies and procedures. I understand that my failure to do this can lead to a Medicaid fraud investigation. If I have additional questions regarding the Self-Directed program, I may contact the local Regional Program Officer with the Senior and Long Term Care Division, Department of Public Health and Human Services.

_______________________________ _______________
Personal Representative Date

_______________________________ _______________
Witness Date

To participate in this program, as the personal representative, you are responsible for the following:

1. Obtaining approval from the consumer's physician or a health care professional to participate. Under this program, a health care professional is defined as a physician assistant certified, nurse practitioner, registered nurse, occupational therapist, or a medical social worker as a member of a case management team for the purposes of the Home and Community Based Services program.

2. Obtaining approval from the health care professional to manage health related tasks. This approval may be limited or include the full scope of the task. For any health related tasks authorized by the health care professional, access to Medicaid Home Health services will be limited.

3. Select a provider in your area that you wish to work with. This provider will become the employer of record for your attendants, assist with the necessary paper work and act as a liaison with the Department.

(Continued on back)

Distribution: White-Provider; Yellow-Consumer, Pink-Personal Representative

4. Develop and maintain a service plan readily available in the home. It must include:
   a) a consumer profile completed by the provider to establish the service limit in terms of hours;
   b) an emergency back up plan which addresses the process you will follow when and if an attendant fails to show. The back up plan may not be Medicaid Personal Assistance Services managed by an agency or home health services for authorized health maintenance tasks. These services become available only when and if the emergency backup plan fails;
   c) a training plan for attendants performing health related tasks, should the consumer's physician or health care professional authorize them;
   d) the method you will use to recruit attendants; and
   e) a schedule of oversight visits which is no less than once every 180 days.

5. Recruit, train, schedule and manage all attendants who will provide services. This includes directing the day to day care of the consumer. Resolve any attendant/consumer disputes which may arise. A personal representative is available to provide backup services. Reimbursement is not available for personal representative activities.

6. Review and approve all service delivery records to insure the service plan has been followed, thereby authorizing for Medicaid to be billed. **MISREPRESENTATION WITHIN THESE DOCUMENTS CONSTITUTES FRAUD.** The personal representative can be held accountable for knowingly approving service delivery records that contain fraudulent information, resulting in over billing Medicaid.

7. Obtaining re-certification for continued participation every 180 days from the provider agency. Obtain annual approval from the health care professional.

8. Participation in compliance reviews conducted by the Department. These reviews are designed to insure that services are being delivered in accordance to the policies of the Department. This may include a review of home records.

9. Medical and related liability regarding the delivery of Personal Assistance Services. According to the statutory language which created this program, you will be responsible for any incidents of harm.

10. Amend the consumer's plan of care should you choose to no longer manage health maintenance tasks. As long as it appears on your plan of care, the consumer is unable to access home health agency services for the same activity.

11. Appoint a temporary personal representative should you leave the area for a short period of time.

Department of Public Health and Human Services SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	**SECTION:** FORMS **SUBJECT:** Provider Prepared Standards

PURPOSE: The purpose of the provider prepared standards is to obtain valuable information about the agency's program directly from the agency. This allows the bureau to review specific criteria in an efficient manner.

PROCESS: Regional Program Officers will use these guidelines to determine compliance with provider prepared standards.

1. Provider reports and follows up on all serious occurrences.

   A. Evaluate whether the provider analyzed the type of occurrences.

   B. Review your records to determine if serious occurrences are being reported.

   C. To achieve compliance, both A & B must be positive.

2. An annual recipient survey is conducted and the results are utilized to improve services.

   A. Review the copy of the provided survey.

   B. Determine whether the summarized results are consistent with any plans to implement changes.

   C. To achieve compliance, both A & B must be positive.

   D. If the survey is in process, do not determine compliance until documentation is provided that the process has been completed within a specific time frame.

3. The provider has current workers' compensation, liability and auto coverage.

   A. Review attached insurance binders.

   B. Auto coverage is for non-owned vehicles or vehicles for hire.

   C. To achieve compliance, provider must have all required coverages. If not, suspension of provider may be necessary until proof is provided.

4. Consumers/Personal representatives receive appropriate information about the program.

   A. Review information provided to consumers to insure accuracy. To achieve compliance, information must be accurate.

   B. Review SDPAS 602 & SDPAS 702 to insure that information is provided. The information must be provided to achieve compliance.

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Provider:	Provider #:
Person Completing Review:	Title:
Date Completed:	Date of Review:

A. SERIOUS OCCURRENCES

Provider reports and follows up on all serious occurrences.

Describe in detail the process for staff to report serious occurrences.

Review serious occurrence reports of the last quarter/year. What type of incident occurs most often? What do you believe is the cause? Are there methods to reduce the number of these incidents?

B. RECIPIENT SURVEY

An annual recipient survey is conducted and results are utilized to improve services.

Attach a copy of the last survey and indicate the following:

Month last survey was conducted:	Type of survey: (mail, phone, etc.)	
Number of surveys sent:	Number Returned:	%:

Summary of survey results:

How were these results used? What if any changes were made?

C. PROVIDER REQUIREMENTS

The provider has current worker's compensation, liability and auto coverage.

Attach documentation of current coverage.

Explain any lapses in coverage

D. CONSUMER INFORMATION

Consumers/ Personal Representative receive appropriate information about the program.

Attach copies of any material provided to consumers at intake or during nurse supervisor visits.

If none, explain why.

PROVIDER COMMENTS REGARDING THIS EXERCISE

PROVIDER SUGGESTIONS FOR PROGRAM IMPROVEMENT

SIGNATURE: DATE:

RPO REVIEW & SIGN OFF	
A:	
B:	
C:	
D:	
COMMENTS:	
The prepared standards meet / do not meet DPHHS requirements: RPO SIGN OFF:	DATE:

PURPOSE--Often times providers are seriously concerned about another provider's performance in serving our clients. The Request for Case Review form gives them a vehicle on which to note their concerns and forward them to the state office. Use this form with discretion.

Program--Enter the type of provider you are concerned about, i.e., personal assistance, home health, HCBS, etc.

Date--Enter the date on which you are completing the form.

Consumer--If your concern involves a single consumer, fill in the individual's name.

Medicaid ID--Enter the consumer's Medicaid ID number.

Reporter--Enter your name and agency. This field is optional.

PROVIDER:

Describe what is happening--Give specific examples with dates and times whenever possible. For example, "worker left 30 minutes early Wed July 21 and Friday July 23 without explanation"; or, "on June 3 client complained that nurse is not changing dressing as indicated in his POC."

Services in place--If your concern is for a specific individual, indicate all the services the consumer is receiving. Otherwise write N/A.

Concern--Clearly state your concern. This means what could result from what is happening. For example, "individual not receiving allocated hours"; or, "individual's health is at risk because wound is not being cared for properly."

Resolved--If you have contacted the agency and have been able to resolve this issue, check the yes box. If not, check the no box.

Forward all copies to the Senior and Long Term Care Division to the attention of the program manager responsible for the service you are concerned about. (Refer to PAS 802.)

DPHHS The program manager will complete this section.

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STATE OF MONTANA
Department of Public Health and Human Services

REQUEST FOR CASE REVIEW

PROGRAM ______________________ DATE: ______________
RECIPIENT ______________________ MEDICAID ID # ______________
REPORTER (Optional): ______________________

PROVIDER

Describe what is happening:

Services in Place:

Concern :

Resolved: Yes ☐ No ☐
(Forward all copies to Senior & Long Term Care, DPHHS, PO Box 4210, Helena, MT 59604 for completion.)

DPHHS

BUREAU ACTION:

Cause: ______________________

____

____

____

Resolution: ______________________

____

____

Adult Protective Services Yes ☐ No ☐

______________________ ______________
(Signature) **(Date)**

Distribution: White-Agency; Yellow-DPHHS; Pink-DPHHS

Subchapter 4

Provider Requirements

37.85.401 PROVIDER PARTICIPATION (1) As a condition of participation in the Montana medicaid program all providers must comply with all applicable state and federal statutes, rules and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the medicaid program and all applicable Montana statutes and rules governing licensure and certification. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

NEXT PAGE IS 37-19503

37.85.402 PROVIDER ENROLLMENT AND AGREEMENTS

(1) Providers must enroll in the Montana medicaid program for each category of services to be provided. As a condition of granting enrollment approval or of allowing continuing enrollment, the department may require the provider to:

(a) complete and submit an enrollment application or form;

(b) complete and submit agreements or other forms applicable to the provider's category of service;

(c) provide information and documentation regarding ownership and control of the provider entity and regarding the provider's ownership interest or control rights in other providers that bill medicaid;

(d) provide information and documentation regarding:

(i) any sanctions, suspensions, exclusions or civil monetary penalties imposed by the medicare program, any state medicaid program or other federal program against the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider; and

(ii) any criminal charges brought against and any criminal convictions of the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider related to that person s or entity's involveme nt in medicare, medicaid or the Title XX services program; and

(e) submit documentation and information demonstrating compliance with participation requirements applicable to the provider's category of service.

(2) Providers shall provide the department's fiscal agent with 30 days advance written notice of any change in the provider's name, address, tax identification number, group practice arrangement, business organization or ownership.

(a) An enrolled provider is not entitled to change retroactively the category of service for which the provider is enrolled, but must enroll prospectively in the new progr am category. The change in service category will be effective only upon approval of a completed enrollment application for the new service category and on or after the effective date of all required licenses and certifications. The change will apply only to services provided on or after the effective date of the enrollment change.

(3) Except as provided in (2)(a), an approved enrollment is effective on the later of:

(a) 1 year prior to the date the completed enrollment application is received by the department's fiscal agent; or

(b) the date as of which all required licenses and certifications are effective.

(4) Providers, whose services are covered by the Title XVIII program (medicare), shall meet the certification standards of medicare except as provided otherwise in these rules.

(5) Providers shall render services to an eligible medicaid recipient in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations.

(a) No provider may deny services to any recipient because of the recipient's inability to pay a copayment in ARM 3 7.83.826 or in ARM 37.85.204.

(6) Providers shall not discriminate illegally in the provision of service to eligible medicaid recipients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), The Age Discrimination Act of 1975 (42 USC 6101, et seq.), The Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended and all regulations and rules implementing the statutes. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1987 MAR p. 900, Eff. 6/30/87; AMD, 1987 MAR p. 1116, Eff. 7/17/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

Rules 03 through 05 reserved

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37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) Providers must submit clean claims to medicaid within the latest of:

(a) 12 months from the latest of:

(i) the date of service;

(ii) the date retroactive eligibility is determined; or

(iii) the date disability was determined;

(b) 6 months from the date on the medicare explanation of benefits approving the service, if the medicare claim was timely filed and the recipient was medicare eligible at the time the medicare claim was filed; or

(c) 6 months from the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in (1)(a) and (b).

(2) For purposes of this rule:

(a) "Clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service;

(b) For inpatient hospital services, date of service is the date of discharge;

(c) The date of submission to the medicaid program is the date the claim is stamped "received" by the department or its designee; and

(d) The claim submission deadline specified in (1) applies regardless of whether or not a third party has allowed or denied a provider's claim. If a third party has not allowed or denied a provider's claim, the provider may submit a claim to medicaid according to the requirements of ARM 37.85.407(6)(c) and subject to the claim submission deadline specified in (1).

(3) Claims must be submitted in accordance with this rule to be valid. In processing claims, the department or its agent may deny payment of or pend a claim upon determining that a basis exists for denial of payment or pending the claim. No further review or processing of a denied claim is required until resubmission of the claim by the provider. The department or its agent is not required to list or identify all possible grounds for denial or pending of the claim. The fact that a particular basis for denial or pending of a claim for a service or item was not identified on an earlier statement of remittance or other similar statement does not preclude denial or pending of the claim on that basis on a later submission of the claim.

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(4) Except as provided in (7) of this rule, all medicaid claims submitted to the department are to be submitted on a state claim form which is:

(a) personally signed by that provider;

(b) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization; or

(c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer generated, typed or block letter signature shall bear full responsibility f or submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(5) All medicaid claims submitted to the department by a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be submitted on a state claim form which is:

(a) personally signed by the physician provider;

(b) personally signed by a person who has actual written authority to bind and represent the physician provider for t his purpose. The department may require a provider to furnish this written authorization; or

(c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility f or submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(6) The department may require a hospital provider to obtain on the claim form the signature of a physician providing services for which fees are relinquished to the hospital.

(7) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.

(8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under (b) above.

(a) Electrodiagnostic procedures include echocardiology studies, electroencephalography studies, electrocardiology studies, evoked potential studies, holter monitors, telephonic or teletrace checks and pulmonary function tests.

(b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this subsection, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.

(9) If the department pays a claim but subsequently discovers that the provider was not entitled to payment for any reason, the department is entitled to recover the resulting overpayment as provided in (10).

(10) The department is entitled to recover from the provider and the provider is obligated to repay to the department all medicaid payments made to which the provider was not entitled under applicable state and federal laws, regulations and rules. At the option of the department, recoveries may be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment must be made in accordance with ARM 37.85.512.

(a) The department is entitled to recover under (10) any payment to which the provider was not entitled, regardless of whether the payment was the result of department or provider error, or other cause, and without proving that the provider submitted an improper or erroneous claim knowingly, intentionally, or with intent to defraud.

(b) The department is entitled to recover an overpayment from the provider in whose name the erroneous or improper claim was submitted, even if the provider was an employee of another individual or entity and was required as a condition of the provider's employment to turn over all fees received by the provider to the employer.

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(11) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service or item provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative, except as provided in these rules. A provider may bill a recipient for the copayments specified in ARM 37.83.826 and 37.85.204 and may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in ARM 37.83.825.

(a) A provider may bill a recipient for noncovered services if the provider has informed the recipient in advance of providing the services that medicaid will not cover the services and that the recipient will be required to pay privately for the services, and if the recipient has agreed to pay privately for the services. For purposes of (11)(a), non-covered services are services that may not be reimbursed for the particular recipient by the Montana medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana medicaid program for the particular recipient if all applicable requirements, including medical necessity, are met.

(b) Except as provided in this rule, a provider may not bill a recipient after medicaid has denied payment for covered services because the services are not medically necessary for the recipient.

(i) A provider may bill a recipient for covered but medically unnecessary services, including services for which medicaid has denied payment for lack of medical necessity, if the provider specifically informed the recipient in advance of providing the services that the services are not considered medically necessary under medicaid criteria, that medicaid will not pay for the services and that the recipient will be required to pay privately for the services, and the recipient has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the recipient indicating that the service will not be paid by medicaid. The provider may not bill the recipient under this exception when the provider has informed the recipient only that medicaid may not pay or where the agreement is contained in a form that the provider routinely requires recipients to sign.

(ii) An ambulance service provider may bill a recipient after medicaid has denied payment for lack of medical necessity.

(c) A provider may not bill a recipient for services as a private pay patient if, prior to provision of the services, the recipient informed the provider of medicaid eligibility, unless, prior to provision of the services, the provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(d) In service settings where the recipient is admitted or accepted as a medicaid recipient by a provider, facility, institution or other entity that arranges provision of services by other or ancillary providers, all other or ancillary providers will be deemed to have accepted the individual as a medicaid recipient and may not bill the recipient for the services unless, prior to provision of services, the particular provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(e) The provider may not bill a recipient for services when medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing or other requirements necessary to obtain payment.

(f) Acceptance of a recipient as a medicaid recipient applies to all services provided by the provider to the recipient, except as provided in (11)(a) or (b). A provider may not accept medicaid payment for some covered services but refuse to accept medicaid for other covered services. Subject to the requirements of ARM 37.85.402(4), a provider may terminate acceptance of medicaid for a recipient in accordance with the provider's professional responsibility, by informing the recipient of the termination and the effect of the termination on provision of and payment for any further services.

(g) If an individual has agreed prior to receipt of services that payment will be made from a source other than medicaid but later is determined retroactively eligible for medicaid, the provider may choose to accept the individual as a medicaid recipient with respect to the services or to seek payment in accordance with the original payment agreement.

(h) A provider that bills medicaid for services rendered will be deemed to have accepted the individual as a medicaid recipient.

(i) Nothing in this rule is intended to permit a provider to refuse to accept an individual as a medicaid recipient where the provider is otherwise required by law to accept an individual as a medicaid recipient.

(12) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

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(13) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

(14) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

(15) A government agency may bill the medicaid program for covered medical services under the following circumstances:

(a) The government agency has complied with all federal and state law governing the medicaid program, and assures that the provider has complied with all state and federal law governing the medicaid program, including reimbursement levels.

(b) The government agency accepts assignment from an eligible medicaid provider for services provided prior to eligibility determination.

(16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides. Other providers, including but not limited to hospitals, nursing facilities and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the medicaid rules and manual and any supervision requirements in state law or rule governing professional practice.

(17) Medicaid coverage and reimbursement is available only for services or items that are provided in accordance with all applicable medicaid requirements and within the scope of practice permitted under state licensure laws and other mandatory standards applicable to the provider.

(18) Except as otherwise provided in the rules of the department which pertain to the method of determining payment rates for claims of recipients who have medicare and medicaid coverage (cross-over claims), the medicaid allowed amount for medicare covered services is:

(a) for facility based providers who generally bill on the UB-92 billing form, for covered medical services the full medicare co-insurance and deductible as defined by the medicare carrier;

(i) there is an exception for inpatient ancillary services with medicare Part B coverage only (no medicare Part A) or FQHCs: medicare payments for these services are treated as third party payments and are offset against the medicaid payment;

(b) for medical providers who generally bill on the HCFA-1500 billing form, for covered medical services the lower of:

(i) the medicare co-insurance and deductible (if not met); or

(ii) the medicaid fee less the amount paid by medicare for the same service, not to exceed the medicaid fee for that service;

(c) for mental health services that are subject to the medicare psychiatric reduction, the lower of:

(i) the medicaid allowed amount; or

(ii) the medicare allowed amount, less the medicare paid amount;

(d) for services to recipients eligible to receive both medicare and medicaid benefits, an amount not to exceed the medicare allowed amount in instances where the medicaid fee is higher than the medicare allowable.

(19) For all purposes of this rule, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged to all payers.

(20) Reimbursement from medicaid may not exceed an amount which would cause total payment to the provider from both medicaid and all other payers to exceed the medicaid fee. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1981 MAR p. 530, Eff. 5/29/81; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 771, Eff. 7/31/81; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1990 MAR p. 379, Eff. 2/23/90; AMD, 1990 MAR p. 1586, Eff. 8/17/90; AMD, 1992 MAR p. 234, Eff. 2/14/92; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 479; AMD, 2001 MAR p. 1476, Eff. 8/10/01.)

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37.85.407 THIRD PARTY LIABILITY (1) No payment shall be made by the department for any medical service for which there is a known third party who has a legal liability to pay for that medical service except for those services specified in (6) below.

(2) For purposes of this section, the following definitions apply:

(a) A third party is defined as an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the department or a county and includes but is not limited to insurers, health service organizations, and parties liable or who may be liable in tort. Indian health services is not a third party within the meaning of this definition.

(b) A known third party is a third party for which the provider has sufficient information to submit a claim and which if billed for a medical service is likely to pay the claim within a reasonable time.

(c) A potential third party is a third party for which the provider either has insufficient information to submit a claim or which if billed for a medical service, is likely to deny the claim as having no contractual or legal obligation to pay.

(3) For known recipients, the provider shall use its same usual and customary procedures for inquiring about possible third party resources as is done for non-recipients.

(4) If the provider delivers to a recipient or a recipient's legal representative a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.

(a) The words "medicaid has assignment of, or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

(b) If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.

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(5) If a provider learns of the existence of a known third party, that provider shall bill the third party prior to billing the department. If the department has knowledge of a known third party and the provider has not complied with (6) or (7) below, the department shall deny payment of the services.

(6) The department shall not deny payment of services solely because of the existence of a third party in the following circumstances:

(a) The primary diagnosis on the claim is for certain prenatal and preventive pediatric care as specified in the medicaid provider manual, copies of which may be obtained from the Montana Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The provider may bill the third party or the department in this circumstance.

(b) The third party is an insurer under a health insurance policy provided by the absent parent of a recipient and that health insurance is obtained or maintained as a result of an enforcement action taken by the child support enforcement division against that absent parent, if the following provisions are met:

(i) the provider submits evidence that the third party has been billed;

(ii) the claim is submitted to the department 30 or more days beyond the date of service and in compliance with the timely filing rules in ARM 37.85.406(1);

(iii) the provider certifies on the claim that notice of payment or denial of the claim has not been received from the third party; and

(iv) the claim is submitted directly to the third party liability unit (hereafter referred to as the TPL unit) within the department.

(c) The provider has billed the third party and has not received a reply from the third party either allowing or denying payment, if the following provisions are met:

(i) the provider submits evidence of the date the third party was billed;

(ii) the claim is submitted 90 or more days beyond the date established in (c)(i) and in compliance with the timely filing rules in ARM 37.85.406(1);

(iii) the provider certifies on the claim that notice of payment or denial has not been received; and

(iv) the provider submits the claim directly to the TPL unit.

(d) The claim is for services for which the department has been granted a waiver from use of the cost avoidance method and the department has chosen to use and continue to use that waive r, as identified in the medicaid provider manual.

(e) The provider is unable to obtain a valid assignment of benefits, if the following provisions are met:

(i) the provider submits documentation that it attempted to obtain assignment;

(ii) the provider certifies on the claim that assignment could not be obtained; and

(iii) the provider submits the claim directly to the TPL unit.

(f) The third party is only a potential third party as defined in (2)(c).

(7) Except as stated in (8), the department shall pay its allowed amount for services, less any known third party payments for those services, for any claim where a known third party exists in the following circumstances:

(a) the claim is submitted under the provisions of (6);

(b) the submitted claim clearly indicates the amount paid by the third party and includes whatever documentation is received regarding the payment from the third party; or

(c) the claim is submitted with a denial document which clearly shows that the third party denied the claim.

(8) For inpatient hospital claims where medicare Part A benefits have been paid, the department's sole obligation shall be to pay the medicare Part A deductible. For nursing facil ity service claims where medicare Part A benefits have been paid, the department's sole obligation shall be to pay in accordance with ARM 37.40.307.

(9) In the event the provider receives a payment from a third party after the department has made payment, the provider shall refund to the department, within 60 days of receipt of the third party payment, the lesser of the amount the department paid or the amount of the third party payment.

(a) The refund shall be made payable to Montana medicaid and submitted to the department's fiscal office, and shall indicate the name of the third party payor.

(b) The provider is entitled to retain any third party payments which exceed the medicaid allowed amount if all medicaid payments toward those services have been refunded to the department as required in this subsection.

(10) The department shall make no payment for services in those cases where, if the patient were not a medicaid recipient, the third party payment would constitute full payment with no further obligation owing from the recipient.

(11) For any service where an identified third party has only a potential liability as a tort-feasor, the provider may file a medical lien against that third party. The provider may bill the department prior to determination of liability of the third party if the provider notifies the TPL unit of the identity of the third party and its name and address if known. The provider may keep its lien in place and rec eive payment from the third party. If payment is received from the third party, the provider must refund to the department as described in (9).

(12) A provider may not refuse to furnish services to a recipient based upon a third party's potential liability for the service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; AMD, 1990 MAR p. 1719, Eff. 8/31/90 ; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

Rules 08 and 09 reserved

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37.85.410 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

(3) The department may review the medical necessity of services or items at any time either before or after payment. If the department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements. The department is not precluded by an earlier screening, prior authorization, certification or similar process from reviewing and determining medical necessity of any service or item, or from denying payment or recovering any overpayment based upon any such review or determination. This rule does not require the department to notify a provider or recipient of a medical necessity determination until and unless the department completes its review and takes an adverse action against the provider based upon the determination.

(4) The provider must upon request provide to the department or its designated review organization without charge any records related to services or items provided to a recipient. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6- 111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

37.85.411 PROVIDER RIGHTS (1) Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action which directly affects the rights or entitlements of the provider under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(2) Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action affecting the applicant's or recipient's eligibility under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(3) This rule does not grant to providers any right to notice of actions affecting recipients, including but not limited to eligibility determinations. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-14 1, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Rules 12 and 13 reserved

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37.85.414 MAINTENANCE OF RECORDS AND AUDITING (1) All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana medicaid recipients which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

(a) In maintaining financial records, providers shall employ generally accepted accounting methods. Generally accepted accounting methods are those approved by the national association of certified public accountants.

(b) The department shall have access to all records so maintained and retained regardless of a provider's continued participation in the program.

(c) In the event of a change of ownership, the original owner must retain all required records unless an alternative method of providing for the retention of records has been established in writing and approved by the department.

(2) In addition to the recipient's medical records, any medicaid information regarding a recipient or applicant is confidential and shall be used solely for purposes related to the administration of the Montana medicaid program. This information shall not be divulged by the provider or his employees, to any person, group, or organization other than those listed below or a department representative without the written consent of the recipient or applicant.

(3) The department, the designated review organization, the legislative auditor, the department of public health and human services, the department of revenue, the medicaid fraud co ntrol unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by this rule.

(a) Refusal to permit inspection, evaluation or audit of services shall result in the imposition of provider sanctions in accordance with the rules of the department.

(4) The provisions of this rule specifying the length of time for which records must be retained shall not be construed as a limitation on the period in which the department may recover overpayments or impose sanctions. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

37.85.415 MEDICAL ASSISTANCE MEDICAID PAYMENT

(1) Medicaid will pay only for medical expenses:

(a) incurred by a person eligible for the medicaid program;

(b) for services provided for and to the extent provided for under the medicaid program;

(c) for which third party payment is not available;

(d) not used to meet the incurrment requirement at ARM 37.82.1101 and following rules for persons who are medically needy;

(e) which are not the copayment provided for in ARM 37.85.204; and

(f) to the extent allowed by medicaid. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 479.)

37.85.416 STATISTICAL SAMPLING AUDITS (1) At the option of the department, the amount of money erroneously paid to a provider for any given period of time may be determined by the use of statistical sampling and extrapolation, rather than by an audit of 100% of the claims submitted by the provider during the period of time under review. Statistical sampling and extrapolation shall not be used to determine overpayments for inpatient hospital services, outpatient hospital services, or hospital inpatient psychiatric services, or in cases where the number of line items in the review period does not equal 500 or more.

(a) A line item consists of a single service, under one procedure rate with one or more units of service, procedure or item on a medicaid claim form for which a provider has received payment.

(2) If the department chooses to use statistical sampling and extrapolation to determine an overpayment, it will use a statistical method to draw a random sample of claims for the review period and will audit these claims. The department will calculate the provider's error rate based on the net dollar amount overpaid to the provide r after any underpayments occurring in the sample have been offset against the overpayments occurring in the sample. The department will then calculate the total overpayment for the review period using an appropriate statistical methodology.

(3) If the department chooses to use statistical sampling and extrapolation, it shall notify the provider of its intention to do so. When the sampling and extrapolation process is completed, the department shall provide the provider with information regarding the sample size, the sample selection method, and the formulas and calculations used in the extrapolation.

(4) It is presumed that the overpayment amount determined by the use of statistical sampling and extrapolation is correct. However, the provider may rebut this presumption by presenting evidence that the sampling and extrapolation process used by the department was invalid, by presenting evidence that claims in the sample determined by the department to be erroneous or overpaid were correctly paid, or by requesting an audit of 100% of the claims paid in the review period, as provided in (5).

(5) A provider who does not agree with the overpayment amount determined by statistical sampling may re quest that the department conduct a 100% audit of the claims paid in the review period. The request for a 100% audit must be made within 30 days of the date of the notice informing the provider of the results of the statistical sampling. The department must then conduct such a review.

(a) If the audit shows an overpayment amount which is different from the overpayment amount determined by sampling and extrapolation, the amount determined by the audit shall be used by the department in assessing an overpayment against the provider. A provider who is aggrieved by a department determination based upon the results of the audit may appeal by means of the fair hearing procedures set forth in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(b) The provider must pay the department's costs for such an audit, unless the overpayment amount determined by the 100% audit is at least 10% less than the overpayment amount determined by the statistical sample.

(6) A provider who is aggrieved by an overpayment determined by statistical sampling and extrapolation may appeal by means of the fair hearing procedures set forth in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 1993 MAR p. 441, Eff. 3/26/93; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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Subchapter 5

Provider Sanctions

37.85.501 GROUNDS FOR SANCTIONING (1) Sanctions may be imposed by the department against a provider of medical assistance, provided under this chapter; Title 37, chapters 40, 80, 82, 83, 85, 86, 88, ARM 37.85.415; ARM 37.83.201 and 37.83.202, and Title 46, chapter 25, for any one or more of the following reasons:

(a) Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

(b) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled under the rules of the department.

(c) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(d) Failure to maintain and retain records required by the rules of the department.

(e) Failure to disclose or make available required records to the department, its authorized agent or other legally authorized persons, organizations, or governmental entities.

(f) Failure to provide and maintain services to medicaid recipients at a quality that is within accepted medical community standards as adjudged by a body of peers.

(g) Engaging in a course of conduct or performing an act which the department's rules or the decision of the applicable professional peer review committee, or licensing board, have determined to be improper or abusive of the Montana medicaid program; or continuing such conduct following notification that the conduct should cease.

(h) Breach of the terms of the provider contract or failure to comply with the terms of the provider certification on medical assistance claim forms or the failure to comply with requirements imposed by the rules of the department.

(i) Over-utilizing the Montana medicaid program by inducing, or otherwise causing a recipient to receive services or goods not medically necessary.

(j) Rebating or accepting a fee or portion of a fee or charge for a medicaid patient referral.

(k) Violating any provision of the state medicaid law, Title 53, chapter 6, MCA or any rule promulgated pursuant thereto, or violating any provision of Title XIX of the Social Security Act or any regulation promulgated pursuant thereto.

(l) Submission of a false or fraudulent application for provider status.

(m) Violations of any statutes, regulations or code of ethics governing the conduct of occupations or professions or regulated industries.

(n) Conviction of a criminal offense relating to medical assistance programs administered by the department or provided under contract with the state; or conviction for negligent practice resulting in death or injury to patients.

(o) Failure to meet requirements of state or federal law for participation (e.g. licensure).

(p) Exclusion from the medicare program (Title XVIII of the Social Security Act) because of fraudulent or abusive practices.

(q) Charging medicaid recipients for amounts over and above the amounts paid by the department for services rendered, except as specifically allowed under ARM 37.83.825 and 37.83.826.

(r) Refusal to execute a new provider agreement when requested to do so.

(s) Failure to correct deficiencies as defined by the ARM or federal regulation after receiving written notice of these deficiencies from the department, or the federal department of health and human services. The standards set forth at 42 CFR Part 442 and the amendments proposed to this section as published in the federal register, vol. 52, no. 126 on July 1, 1987, at page 24752 et seq. which identify deficiencies for providers of long term care facility services, are hereby incorporated by reference. A copy of 42 CFR Part 442 and the amendments proposed to this section as published in the federal register, vol. 52, no. 126 on July 1, 1987, at page 24752 et seq. are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(t) Formal reprimand or censure by an association of the provider's peers for unethical practices.

(u) Suspension or termination from participation in another government medical program including but not limited to workers' compensation, crippled children's services, rehabilitation services and medicare.

(v) Filing of criminal indictment, information or complaint for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(w) Civil judgement for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(x) Failure to repay or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments.

(y) Threatening, intimidating or harassing patients or their relatives in an attempt to influence reimbursement rates or affect the outcome of disputes between the provider and the department.

(z) Submitting claims for reimbursement of costs or services which the provider knows or has reason to know are not reimbursable. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-2-803, 53-4-112, 53-6-111 and 53-6-131, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1986 MAR p. 1321, Eff. 8/1/86; AMD, 1987 MAR p. 2164, Eff. 11/28/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.502 SANCTIONS (1) The following sanctions may be invoked against providers based on the grounds specified in ARM 37.85.501:

(a) Termination from participation in the medical assistance program.

(b) Suspension of participation in the medical assistance program.

(c) Suspension or withholding of payments to a provider.

(d) Shortening of an existing provider agreement as permitted by the terms of such agreement.

(e) Required attendance at provider education sessions, the cost of which shall not be reimbursed by the department or any of its programs.

(f) Required prior authorization for provision of services.

(g) 100% review of the provider's claims prior to payment.

(h) Referral to the department of revenue for any action deemed necessary.

(i) In addition to the sanctions listed above, long term care facilities shall be subject to termination of participation when the deficiencies resulting from failure to meet conditions or standards of participation pose immediate jeopardy or the denial of payments for new admissions if the facility's deficiencies resulting from failure to meet conditions or standards of participation do not pose immediate jeopardy. Federal laws regarding termination from participation and intermediate sanctions provided in 42 U.S.C. 1396a(i), 42 CFR 442.2, and 42 CFR 442.117 through 442.119 are hereby incorporated by reference. A copy of 42 U.S.C. 1396a(i), 42 CFR 442.2, and 42 CFR 442.117 through 442.119 may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; or

(j) Notification to the public of sanctions taken against a provider.

(History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87; TRANS, from SRS, 2000 MAR p. 479.)

Rules 03 and 04 reserved

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37.85.505 FACTORS GOVERNING IMPOSITION OF SANCTION

(1) The decision to impose sanctions and which sanctions to impose shall be within the discretion of the department except as provided in (3).

(2) The following factors shall be considered in determining the sanction(s) to be imposed:

(a) seriousness of the offense(s);

(b) extent of violations;

(c) history of prior violations;

(d) prior imposition of sanctions;

(e) prior provision of provider education;

(f) provider willingness to comply with program rules;

(g) whether a lesser sanction will be sufficient to remedy the problem;

(h) actions taken or recommended by peer review groups or licensing boards.

(3) Where a provider has been found by a court of competent jurisdiction in either a civil or criminal proceeding to have defrauded the Montana medical assistance program, or has been previously suspended due to program abuse, or has been terminated from the medicare program for fraud or abuse, the department may terminate the provider from the medical assistance program. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.506 SCOPE OF SANCTION (1) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due consideration to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to an affiliate where such conduct was accomplished within the course of the affiliate's official duty or was effectuated by the provider with the knowledge or approval of the affiliate.

(2) Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the department or its fiscal agents for any services or supplies provided to persons eligible for the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to 30 days after the date of termination to allow for the transfer of recipients.

(3) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the department or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to 30 days after the date of termination to allow for the transfer of recipients.

(4) When the provisions of (3) of this rule are violated by a provider of services which is a clinic, group, corporation, the department may suspend or terminate such organization and/or any individual person within said organization who is responsible for such violation. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.507 NOTICE OF SANCTION (1) When a provider has been suspended or terminated, the department shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed. (History: Sec. 53-6-111, MCA; IMP, Sec. 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; TRANS, from SRS, 2000 MAR p. 479.)

Rules 08 through 10 reserved

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37.85.511 PROVIDER EDUCATION (1) Except where termination has been imposed, the department may in its discretion direct each provider, who has been sanctioned, to participate in a provider education program as a condition of continued medicaid participation.

(2) Provider education programs may include any of the following at the discretion of the department:

(a) instruction in claim form completion;

(b) instruction on the use and format of provider manuals;

(c) instruction on the use of procedure codes;

(d) instruction on statutes and regulations governing the Montana medicaid program;

(e) instruction on reimbursement rates;

(f) instructions on how to inquire about coding or billing problems;

(g) any other matter as determined by the department. (History: Sec. 53-6-111, MCA; IMP, Sec. 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; TRANS, from SRS, 2000 MAR p. 479.)

37.85.512 NOTICE OF ADVERSE ACTION (1) As provided in this rule, the department must notify a provider of any adverse action it will take on a determination that the provider has engaged in fraud or abuse or has received payment to which the provider is not entitled. The notification must include:

(a) a description of the fraud, abuse or overpayments;

(b) the dollar value of any overpayment; and

(c) the adverse action to be taken or sanction to be imposed by the department;

(d) explanation of any actions required of the provider;

(e) the provider's right to a fair hearing.

(2) The department is not required to notify a provider pursuant to (1) until after the department has determined that fraud, abuse or an overpayment has occurred, the dollar amount of any overpayment and that a particular adverse action will be taken by the department against the provider, such as recovery of an overpayment or imposition of a sanction. The department is not required to notify the provider when the department merely suspects or has information which suggests that fraud, abuse or an overpayment has occurred or when the department has not determined to take a particular adverse action in response to the fraud, abuse or overpayment.

(3) Subject to the provisions of (4), the department must notify the provider as required in this rule within 45 days after the department has determined that fraud, abuse or an overpayment has occurred, the dollar amount of any overpayment and the advers e action that will be taken against the provider. The department's failure to no tify a provider as required by this rule is not a defense to recovery of the overpayment or imposition of the sanction, but the department may be required to provide a new notice in compliance with this rule.

(4) This rule shall not be construed to require that the department investigate, complete an investigation, make a determination or take any other action regarding a potential fraud, abuse or overpayment within any particular time.

(5) While this rule does not require the department to act within any particular time, if any governmental agency or entity is conducting an investigation of a provider, the department shall not in any event be required to notify the provider of a violation or overpayment until the investigation is concluded and enforcement proceedings, if any, have been completed, if in the sole discretion of the department or the governmental agency or entity conducting the investigation, earlier notification would interfere with or jeopardize the investigation, recovery of an overpayment or imposition of a sanction. (History: Sec. 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

37.85.513 SUSPENSION OR WITHHOLDING OF PAYMENTS PENDING FINAL DETERMINATION (1) Where the department has notified a provider of a violation or an overpayment pursuant to ARM 37.85.512 the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payments pending a final determination.

(2) Where the department intends to withhold or suspend payments it shall notify the provider in writing at least 10 days prior to commencement of withholding and shall include a statement of the provider's right to request an informal reconsideration of such decision as provided in ARM 37.5.305. This rule does not require that an informal reconsideration or any hearing be conducted prior to the withholding or suspension of payments.

(3) Where the department has terminated or suspended a provider, the provider shall be eligible to bill for covered services for the period covered by the suspension or termination if an appeal is decided in the provider's favor. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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Department of Public Health and Human Services	SECTION: RULES AND RESOURCES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Personal Care Rules

SENIOR AND LONG TERM CARE SERVICES

Subchapter 11

Personal Care

Rule 37.40.1101 Personal Care, Services, Services Provided and Limitations

37.40.1102 Personal Care Services, Requirements

Rules 03 and 04 reserved

37.40.1105 Personal Care Services, Reimbursement

37.40.1106 Personal Care Services, Provider Compliance

Subchapter 12 reserved

Subchapter 11

Personal Care

37.40.1101 PERSONAL CARE, SERVICES, SERVICES PROVIDED AND LIMITATIONS (1) Personal care services are medically necessary in-home services provided to medicaid recipients whose health conditions cause them to be functionally limited in performing activities of daily living. Personal care services are intended to prevent or delay institutionalization by providing medically necessary, long-term maintenance or supportive care in the home.

(2) Personal care includes assistance with the following activities:

(a) activities of daily living;

(b) household tasks; and

(c) escort services.

(3) Activities of daily living are limited to bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medication and meal preparation.

(4) Household tasks are limited to housekeeping activities, provided in accordance with the personal care plan and furnished in conjunction with activities of daily living, that are directly related to the recipient's medical needs. Household tasks include only:

(a) cleaning the area used by the recipient;

(b) changing the recipient's bed linens;

(c) doing the recipient's laundry; and

(d) shopping for groceries and household items essential to the health care, nutritional needs, and maintenance of the recipient.

(5) Escort services are provided by a personal care attendant who accompanies the recipient to a medical examination, treatment or for shopping to meet the recipient's essential health care or nutritional needs. Escort services are available to a recipient who requires personal care services enroute or at the destination, when a family member or caregiver is unable to accompany them.

(6) Personal care services may not include any skilled services that require professional medical training unless otherwise permitted under 37-8-103, MCA.

(7) Personal care services may not include services which maintain an entire household or family or which are not medically necessary. Personal care services do not include:

(a) cleaning floors and furniture in areas recipients do not use or occupy;

(b) laundering clothing or bedding recipients do not use;

(c) supervision, respite care, babysitting or visiting;

(d) maintenance of animals unless the animal is a certified service animal specifically trained to meet the safety needs of the recipient; and

(e) home and outside maintenance.

(8) Personal care provided by a member of the recipient's immediate family is not personal care services for the purposes of the medicaid program, and is not eligible for reimbursement.

(a) Immediate family member includes the following:

(i) husband or wife;

(ii) natural parent;

(iii) natural child;

(iv) natural sibling;

(v) adopted child;

(vi) adoptive parent;

(vii) stepparent;

(viii) stepchild;

(ix) step-brother or step-sister;

(x) father-in-law or mother-in-law;

(xi) son-in-law or daughter-in-law;

(xii) brother-in-law or sister-in-law;

(xiii) grandparent;

(xiv) grandchild;

(xv) foster parents; or

(xvi) foster child. (History: Sec. 53-6-113 and 53-6-201, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1102 PERSONAL CARE SERVICES, REQUIREMENTS (1) To qualify for personal care, a person must be medicaid eligible and demonstrate a medical need for personal care.

(2) Personal care services, except for escort services and household tasks, may be provided only in the recipient's home.

(3) Personal care services provided in licensed foster or group homes must be prior authorized by the department. Personal care services may be authorized when the person's medical needs are beyond the scope of services normally provided by programs funding services in foster or group home settings. For example, a person requiring additional assistance because of an acute medical episode or post-hospitalization period may receive personal care services in a foster or group home setting.

(4) Personal care services may not be provided to persons who reside in a hospital or long-term care facility as defined in 50-5-101, MCA, and licensed under 50-5-201, MCA.

(5) The recipient, in order to receive personal care services, must be capable of making choices about activities of daily living, understand the impact of these choices and assume responsibility for the choices or have someone residing within or outside the household willing to assist the recipient in decision making and to direct their activities.

(6) The type and amount of personal care services must be specified in a plan of care which governs delivery of services. The plan of care for a recipient must be approved by a physician and developed by a licensed nurse employed by a provider. The approval of the service plan must be renewed at least annually. The plan of care shall be developed based upon the completion of the department's recipient profile by the provider.

(7) The delivery of personal care services must be supervised by a licensed nurse.

(8) The recipient must agree to accept the provision of personal care services as specified in the plan of care.

(9) Household tasks and escort services must be provided only in conjunction with other persona l care services and must be directly related to a recipient's medical needs.

(10) Household tasks ma y not account for more than 1/3 of the total time allocated per week for personal care services.

(11) Personal care services must be prescribed in writing at least annually by a physician and must be reviewed at least every 180 days by a licensed nurse.

(12) A recipient may receive personal care services through the medicaid home and community based services program for elderly and physically disabled persons or the medicaid home and community based services program for persons with developmental disabilities, in addition to the personal care services provided through these rules.

(13) Personal care providers must be independent contractors for purposes of federal and state wage and hour laws and workers' compensation laws. Personal care providers are limited to businesses incorporated under the laws of the state of Montana. Personal care providers must demonstrate that they are paying workers' compensation and unemployment insurance premiums.

(14) The department will enroll providers who provide the following documentation:

(a) the provider's articles of incorporation;

(b) a written contingency plan, approved by the department, addressing service delivery to clients in the event an agency is unable to deliver services in a timely manner or in the event the agency ceases operation;

(c) general liability insurance with a minimum coverage of $100,000 per person;

(d) motor vehicle liability insurance with a minimum coverage of $100,000 per person;

(e) current unemployment insurance and worker's compensation coverage;

(f) financial solvency, to include the ability to make a projected 4 month payroll; and

(g) a description of the proposed service area which must be defined to include at a minimum coverage of the entire area of at least one county or Indian reservation.

(15) The department may contract with out-of-state agencies to provide personal care services for Montana medicaid recipients living out of state.

(16) Personal care services may only be delivered by a personal care attendant employed by an enrolled medicaid provider that has met the criteria established by the department for the delivery of personal care services.

(17) Personal care services may not be provided to relieve a parent of child caring or other legal responsibilities.

(a) Personal care for disabled children may be appropriate when the parent is unqualified or otherwise unable to provide the personal care and the child is at risk of institutionalization unless the services are provided.

(18) Personal care services must be delivered in the most efficient manner available.

(19) Personal care services are not available to recipients who live in homes which are not safely accessible by normal modes of transportation.

(20) Personal care services may be terminated for any of the following reasons:

(a) the recipient or other persons in the household subjects the personal care attendant to physical or verbal abuse, sexual harassment, exposure to the use of illegal sustances or to threats of physical harm;

(b) the recipient requests termination of services or refuses to accept help;

(c) the environment of the recipient is unsafe for the provision of personal care services;

(d) the recipient's physician requests termination of services;

(e) the recipient no longer has a medical need for personal care services;

(f) the recipient refuses the services of a personal care attendant based solely or partly on the attend ant's race, creed, religion, sex, marital status, color, age, handicap or national origin; or

(g) the recipient refuses to accept services in accord with the plan of care.

(21) The department may terminate or reduce personal care services when funding for services is unavailable.

(22) The provider shall give at least 10 days advance notice to a recipient when personal care services are terminated for reasons listed in (20)(d) through (20)(g).

(23) The provider may immediately but temporarily suspend services for the reasons listed in (20)(a) through (20)(c). Following the temporary suspension of services the provider may enter into an agreement with the recipient to ensure that the violations of (20)(a) through (20)(c) do not reoccur. If the recipient fails to abide by the term of the agreement services may be permanently terminated.

(24) The department shall provide written notice to an applicant when personal care services are initially denied to the applicant.

(25) A person may request a fair hearing for any adverse determination made by the department. Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.310, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53 -6-141, MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1980 MAR p. 2979, Eff. 11/29/80; AMD , 1983 MAR p. 863, Eff. 7/15/83; AMD , 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Rules 03 and 04 reserved

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37.40.1105 PERSONAL CARE SERVICES, REIMBURSEMENT

(1) Personal care services may be provided up to but not more than 40 hours of attendant service per week per recipient as defined by the plan of care. The department may, within its discretion, authorize additional hours in excess of this limit. Any services exceeding this limit must be prior authorized by the department. Prior authorization for excess hours may be authorized if additional assistance is required:

(a) for a period of time not to exceed 3 months and as the result of an acute medical episode;

(b) for a period of time not to exceed 3 months and to prevent institutionalization during the absence of the normal caregiver; or

(c) for a period of time not to exceed 3 months and during a post-hospitalization period.

(2) Reimbursement for personal care services is $2.64 per 15 minute unit of service. The rate is for units of attendant and nurse supervision service.

(a) A unit of attendant service is 15 minutes and means an on-site visit specific to a recipient.

(b) A unit of nurse supervision service is 15 minutes and means an on-site recipient visit and related activity specific to that recipient.

(3) A person retained personally by a recipient to deliver personal care services is not a provider of personal care services for the purposes of this rule and therefore may not be reimbursed for personal care services by the department.

(4) Reimbursement is not available for personal care provided by immediate family members. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1980 MAR p. 2979, Eff. 11/29/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1106 PERSONAL CARE SERVICES, PROVIDER COMPLIANCE

(1) Providers of personal care services shall be subject to compliance reviews to provide assurance t o the department that services are being provided within the rules and policy of the program.

(2) Compliance reviews shall be conducted by department staff on the provider's premises.

(3) The reviews shall take place:

(a) on an annual basis;

(b) 90 days after the enrollment of a new provider; and

(c) at other times as determined by the department.

(4) The department shall determine compliance in the following service delivery areas:

(a) response to referrals;

(b) service initiation;

(c) physician orders;

(d) recipient needs intake;

(e) service delivery;

(f) attendant orientation to recipient;

(g) supervisory visits;

(h) service breaks;

(i) prior authorization; and

(j) service termination.

(5) The department shall determine compliance in the following administrative areas:

(a) attendant basic training;

(b) attendant in service training;

(c) nurse licensure;

(d) response to complaints;

(e) maintenance of incident reports;

(f) recipient surveys;

(g) attendant pool; and

(h) development of agency manuals and handouts.

(6) The department may choose to review other areas of the program at its discretion.

(7) The department shall examine 15 cases or 5% of the provider's case load for the purpose of the compliance review.

(8) The provider must meet all standards in 90% of the cases to be considered in compliance. If 90% compliance is not met, the provider will be given the results of the review and a second compliance review will be scheduled.

(9) The provider must meet all standards in 90% of the cases in the second review or it will be subject to department sanctions as provided in ARM 37.85.401, 37.85.502, 37.85.50 5, 37.85.506, 37.85.507, 37.85.511, 37.85.512 and 37.85.513. (History: Sec. 53-6-101, 53-6-113 and 53-2-201, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1995 MAR p. 1191, Eff. 7/1/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Subchapter 12 reserved

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Department of Public Health and Human Services	SECTION: RULES AND RESOURCES
SELF-DIRECTED PERSONAL ASSISTANCE SERVICES	SUBJECT: Self-Directed Personal Assistance Services Rules

SENIOR AND LONG TERM CARE SERVICES

Subchapter 13

Self-Directed Personal Assistance Services

Rule 37.40.1301 Self-Directed Personal Assistance Services, Description and Purpose

37.40.1302 Self-Directed Personal Assistance Services, Application of General Personal Care Rules

Rules 03 and 04 reserved

37.40.1305 Self-Directed Personal Assistance Services, Consumer Requirements

37.40.1306 Self-Directed Personal Assistance Services, Plan of Care Requirements

37.40.1307 Self-Directed Personal Assistance Services, Provider Requirements

37.40.1308 Self-Directed Personal Assistance Services, General Requirements

Rules 09 through 14 reserved

37.40.1315 Self-Directed Personal Assistance Services, Compliance Reviews

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Subchapter 13

Self-Directed Personal Assistance Services

37.40.1301 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, DESCRIPTION AND PURPOSE (1) Self-directed personal assistance services are medically necessary in-home services provided to medicaid consumers whose disability functionally limits performing activities of daily living, and who take the responsibility or have a representative to take the responsibility of managing the services. Self-directed personal assistance services are intended to provide control of service delivery to the consumer and to allow the consumer to direct health related tasks.

(2) Consumers will provide their physician or health care professional evidence of ability to manage their personal assistance services.

(a) The scope and detail of the evidence shall be determined by the physician or health care professional.

(3) Consumers who are unable to utilize self-directed personal assistance services may receive services through the personal assistance services program managed by provider agencies under agreement with medicaid. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

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37.40.1302 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, APPLICATION OF GENERAL PERSONAL CARE RULES (1) The following ARM cites apply to the self-directed personal assistance services program:

(a) ARM 37.40.1101(2) through (5), (7) and (8), pertaining to a description of services provided;

(b) ARM 37.40.1102(2), (4), (5), (9), (10), (12), (17), (18), (21) and (25), pertaining to requirements, limitations and termination of services;

(c) ARM 37.40.1105 pertaining to reimbursement; and

(d) ARM 37.40.1106(1), (6) and (9), pertaining to compliance reviews. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

Rules 03 and 04 reserved

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37.40.1305 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, CONSUMER REQUIREMENTS (1) To qualify for self-directed personal assistance, the consumer must:

(a) have a medical condition which results in the need for personal assistance services;

(b) be capable of assuming the management responsibilities of assistants or have an immediately involved representative willing to assume this responsibility;

(c) have authorization from a physician or health care professional to participate in the program; and

(d) be capable of making choices about activities of daily living, understand the impact of these choices and assume the responsibility of the choices.

(2) The consumer must be capable of acting as though the personal assistant is their employee for the purposes of selection, management and supervision of the personal assistant, although the personal assistant is the employee of a self-directed personal assistance provider.

(a) The consumer has the primary responsibility in the scheduling, training and supervision of the personal assistant. The consumer has the right to require that a particular assistant discontinue providing services to the consumer.

(b) The consumer may have an immediately involved representative assume some or all of the responsibilities imposed by this rule. An immediately involved representative is a person who is directly involved in the day to day care of the consumer. An immediately involved representative must be available to assume the responsibility of managing the consumer's care, including directing the care as it occurs in the home. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

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37.40.1306 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, PLAN OF CARE REQUIREMENTS (1) A consumer must develop a service plan and have it approved annually by a physician or health care professional prior to receiving self-directed personal assistance services. The plan must include:

(a) the consumer's need for personal assistance services as documented by the provider agency through completion of the department's personal assistance services consumer profile;

(b) tasks assigned to the personal assistant;

(c) an emergency back-up plan;

(d) a training plan for assistants performing health related tasks;

(e) a method for recruiting personal assistants; and

(f) a schedule to update the consumer profile by the provider agency at least once every 180 days. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1307 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, PROVIDER REQUIREMENTS (1) Self-directed personal assistance providers have the following responsibilities:

(a) assist consumers to identify resources for personal assistants;

(b) advise the consumer regarding program participation;

(c) determine the amount of services available to the consumer by completing the consumer profile;

(d) re-certify consumer needs every 180 days;

(e) review the plan of care; and

(f) act as the employer of record for personal assistants for the purposes of payroll and federal hiring practices. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1308 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, GENERAL REQUIREMENTS (1) Health maintenance activities include urinary system management, bowel treatments, administration of medications and wound care.

(2) Self-directed personal assistance providers are limited to businesses organized under the laws of the state of Montana.

(3) Self-directed personal assistance services may only be delivered by an individual who is the employee of a medicaid enrolled provider and who is selected by the consumer or their immediately involved representative.

(4) Personal assistance services managed by provider agencies under agreement with medicaid are not available to individuals participating in the self-directed personal assistance program.

(a) The use of personal assistance services managed by provider agencies may be permissible in the event that the consumer's emergency back up plan fails.

(5) Home health skilled nursing services are not available to consumers for the completion of health maintenance activities which the consumer has been authorized to manage.

(a) The use of home health skilled nursing services may be permissible in the event that the consumer's emergency back up plan fails.

(6) Consumers who have been terminated from the self-directed program may apply for personal assistance services through the medicaid personal assistance services program managed by approved provider agencies. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

Rules 09 through 14 reserved

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37.40.1315 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, COMPLIANCE REVIEWS (1) Compliance reviews shall be conducted on the provider by department staff at the provider's premises.

(a) Completion of the compliance review may require participation from the consumer.

(2) The compliance reviews shall be conducted:

(a) on an annual basis; or

(b) at other times, as determined by the department.

(3) The department shall determine compliance in the following areas:

(a) service delivery;

(b) service authorization;

(c) records maintenance;

(d) assistant surveys; and

(e) consumer surveys.

(4) Providers must achieve a 90% compliance rate as provided in ARM 37.40.1106.

(5) Providers have two opportunities to achieve a 90% compliance rate or the following may occur:

(a) providers shall be subject to department sanctions as provided in ARM 37.85.401, 37.85.502, 37.85.50 5, 37.85.506, 37.85.507, 37.85.511, 37.85.512 and 37.85.513. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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Sources of Reports

Any adult in Montana can request protective services for himself or herself. Any person, entity, or government agency interested in the adult's well being may make a referral.

Elder Abuse Referrals

The Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act requires the following persons to report suspected abuse, neglect, sexual abuse and/or exploitation of an elderly person, disabled, or developmentally disabled adult:

Mandatory Reporters
52-3-811, MCA

1. A physician, resident, intern, professional or practical nurse, physician's assistant, or member of a hospital staff engaged in the admission, examination, care or treatment of persons;

2. An osteopath, dentist, denturist, chiropractor, optometrist, podiatrist, medical examiner, coroner, or any other health or mental health professional;

3. An ambulance attendant;

4. A social worker or other employee of the state, county, or a municipality assisting an older person or a person with a developmental disability in the application for or receipt of public assistance payments or services;

5. A person who maintains or is employed by a rooming house, retirement home, nursing home, group home, or adult foster care home;

6. An attorney, unless he acquired knowledge of the facts required to be reported from a client and the attorney-client privilege applies;

7. A peace officer or other law enforcement official;

8. A person providing services to an older person or a person with a developmental disability pursuant to a contract with a state or federal agency.

Report Content

The following information will be recorded on mandatory CAPS screens RRD1, RRD2, and when necessary RRD3, (see section 401-7) on all reports of alleged abuse, neglect, sexual abuse, or exploitation of eligible persons:

1. Names and addresses of the client and his/her caretaker, if any;

2. Name and address, if available, of the suspected perpetrator who is alleged to have abused, neglected, or exploited the client;

3. To the extent known, the client's age and the nature and extent of the abuse, neglect, sexual abuse, or exploitation, including any evidence of previous injuries sustained by the client;

4. Name and address of the individual making the report.

References

Section 52-3-811, MCA
Section 52-3-812, MCA

MONTANA MEDICAID PROGRAM

Department of Public Health and Human Services
Laurie Ekanger, Director

Health Policy and Services Division
Nancy Ellery, Administrator

PO Box 202951, 1400 Broadway
Cogswell Building, Room A206
Helena, MT 59620-2951
(406) 444- 4540

February 2000

MISSION STATEMENT

To assure that necessary medical care is available to all eligible low income Montanans.

In order to fulfill its mission, the Medicaid program must:

- promote the maintenance of good health by program recipients;
- assure recipients have access to necessary medical care;
- assure that quality of care meets acceptable standards;
- promote the appropriate use of services by recipients;
- promote the delivery of appropriate care by service providers;
- assure that service providers are paid quickly and accurately; and
- assure that services are purchased in a cost-effective manner.

SERVICE DELIVERY COORDINATION

The delivery of services and administrative activities of the Medicaid Program are located primarily within the Health Services and Policy Division. These services are coordinated with many other divisions in the Department of Public Health and Human Services (DPHHS) as well as other state and federal agencies and private providers. Determination of Medicaid eligibility is administered by the DPHHS Division of Human and Community Services through the local County Welfare/Human Services. Eligibility questions should be directed to these offices. Mental health services are administered by the DPHHS Addictive & Mental Disorders Division. Long-term care services are administered by the DPHHS Senior and Long Term Care Division. Utilization review is administered by the DPHHS Quality Assurance Division.

The Division contracts with Consultec, Inc. to enroll Medicaid providers and process Medicaid claims. Consultec's toll free phone number is 1-800-624-3958.

The Division contracts with Maximus to perform much of the administrative oversight for Passport and the HMO Program. Part of their duties include operating a toll free recipient hotline 1-800-362-8312 and a toll free provider hotline 1-800-480-6823.

GENERAL STATEMENT/CO-PAYMENT

Recipients are responsible for paying the co-payment amounts designated by Medicaid. CHILDREN (under age 21), PREGNANT WOMEN, and NURSING HOME RESIDENTS ARE EXEMPT from co-payments. Co-payments MAY NOT be charged for services provided in an emergency or for family planning.

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
1. **Ambulatory Surgical Centers** Bob Wallace 444-7018	Selected procedures provided on an out-patient basis.	ASC must be licensed and meet Medicare participation standards.	Department fee schedule does not include physician services, ambulance, or major prosthetic appliances.	$1.00 per visit..
2. **Audiology Services** (ARM 46.12.533) Kathy Demme 444-4871	Hearing aid evaluation only.	Ordered by physician or mid-level practitioner.	Department fee schedule.	$1.00 per service.
3. **Chemical Dependency Treatment Services (Outpatient)** *Mental & Addictive Disorders* Pete Surdock 444-1290	Intensive outpatient, basic outpatient and aftercare services.	-Must be determined appropriate by a Certified Chemical Dependency Counselor. -Limited to individuals under 21 years of age. -Providers must be approved by Dept. Of Corrections and Human Services.	Department fee schedule.	Exempt.
4. **Chiropractic Services** (ARM 46.12.515) Kathy Demme 444-4871	Manual manipulation of the spine and limited x-rays.	Limited to individuals under age 21.	Department fee schedule.	Exempt.
5. **CLINICS** **Diagnostic Clinic** (ARM 46.12.570, 571, 573) Randy Bowsher 444-3995	Evaluation services in diagnosis and evaluation centers.	Services cannot exceed amount, duration, and scope of services outside clinic setting.	Department fee schedule.	$1.00 per visit.
Federally Qualified Health Centers (FQHC) (ARM 46.12.1701, 1703, 1705 and 1707) Debbie Stipcich 444-4834	Medicaid covered ambulatory services.	Federally deemed clinic receiving or qualified to receive funds under Section 329, 330 or 340 of the Public Health Service Act.	100% of reasonable cost through an all inclusive interim rate and end of period cost settlement.	$2.00 per visit.

EXPERIMENTAL SERVICES A[illegible] NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
Freestanding Dialysis Clinics (ARM 46.12.1501 and 1505) Debbie Stipcich 444-4834	Outpatient maintenance dialysis; training for self dialysis and home dialysis.	Coordinated with Medicare renal disease program; patients must be diagnosed as suffering from chronic ESRD.	All inclusive composite rate for services with a separate fee for drugs.	$2.00 per visit.
Public Health Clinics (ARM 46.12.570, 570 & 573) Randy Bowsher 444-3995	Outpatient physician, nurse specialist, physician assistant, nursing services.		Department fee schedule	$1.00 per visit.
Rural Health Clinics (RHC) (ARM 46.12.1601, 1603, 1605 & 1607) Debbie Stipcich 444-4834	Outpatient services not including dental provided by hospital affiliated-Provider Clinic-or free standing-Independent-clinic.	Medicare certified Clinic located in rural area designated a shortage area by HHS; not a rehab or primarily a facility to treat mental diseases.	Provider Clinics-100% of reason-able cost; Independent Clinics-100% of reasonable cost through an all inclusive interim rate not to exceed an annual cap set by HHS	$2.00 per visit.
Mental Health Services *Addictive & Mental Disorders* Mental Health Help line: . 888-866-0328 Charlies Williams 444-1955	All services medically necessary in the treatment mental illness diagnoses are provided.	Prior authorization required for inpatient, partial hospitalization, residentail treatment, therapeutic group and foster care.	Department fee schedule	$2.00 per visit for practitioner services..
6. **Dental services**, including denture services provided by denturists (ARM 46.12.601) Duane Preshinger 444-3182	Services listed in Department rules.	-Extensive dental services, including dentures, must be prior authorized by the Department. -Services provided by a denturist must be prescribed by a dentist	Department fee schedule.	$1.00 per service.
7. **Dietitian Services** Duane Preshinger 444-3182	Evaluation and treatment by a licensed nutritionist or dietician	Limited to individuals under 21 years of age.	Department fee schedule	Exempt.
8. **Optometric services** (ARM 46.12.901, 902, 905, 911 and 912) Michelle Gillespie 444-4066	Services listed in Department rules.	-Eye examination limited to one annually for individuals 20 & under; limited to one every two years for individuals 21 and over.	Department fee schedule	$1.00 per service

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
9. **Eyeglasses** (ARM 46.12.901, 902, 905, 911 & 912). Michelle Gillespie 444-4066	Services and items listed in Department Rules.	-One pair of eyeglasses every two years for individuals 21 and over, unless there's a significant change in prescription or the individual has had cataract surgery. -Eyeglasses are through Volume Purchasing Contract.	Department fee schedule	$0 for Eyeglasses. $1.00 per dispensing fee.
10. **Family Planning Services** (ARM 46.12.575) Randy Bowsher 444-3995	Family planning services and supplies for individuals of child-bearing age provided by Title X Family Planning Clinics.	-Sterilizations/abortions limited by federal requirements.	Department fee schedule.	Exempt.
11. **Health Maintenance Organizations** (HMOs) Amy Solich 444-4148	Services and items listed in Department Rules.	Only certain services are managed by the HMO. Limited to certain geographic areas.	Per contract.	Exempt for HMO covered service.
12. **Hearing Aids** (ARM 46.12.540) Kathy Demme 444-4871	Hearing Aids, repairs, and accessories.	-Ordered by physician or mid-level practitioner. -Prior authorized by the Department. -Hearing evaluation required by audiologist.	Department fee schedule.	$1.00 per service.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
13. **Home and Community Based Services*** (HCBS Medicaid Waiver) (ARM 46.12.1401) *Senior & Long Term Care* Cecilia Cowie 444-4150 *For Home & Community Based Services for Persons with Developmental Disabilities see number 48 on the last page of this matrix.	In-home services designed to serve individuals in the community who would otherwise require nursing home or hospital care. Services include case management, homemaker, personal care, respite, adult day care, medical alert, environmental modifications/ adaptive equipment, meals, dietitian, social transportation, habilitation, respiratory therapy, nursing & psychological consultation, adult residential, child care for children with AIDS & special services for individuals with a traumatic brain injury.	-Recipient must meet nursing home or hospital level of care and services must be ordered by a physician. -Medicaid cost of care in community cannot exceed cost of institutional care.	Reimbursement varies by service.	Exempt.
14. **Home Health Services** (ARM 46.12.550) *Senior & Long Term Care* Barbara Smith 444-4064	Intermittent skilled nursing services, home health aide services, physical, occupational & speech therapy services and supplies related to services delivered.	-Ordered by a physician. -Limited to a combined maximum 100 visits per state fiscal year except nursing services which have a limit of 75 visits per recipient per state fiscal year. More nursing visits may be available with prior authorization. -All Home Health Aid services must be prior authorized. -Recipient must be homebound OR cannot readily obtain needed medical services other than through a Home Health Agency. -Recipient receiving PCA services may not receive home health aid services.	Department Fee Schedule	$2.00 per service. $.50 per item for equipment and supplies.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
15. **Home Dialysis Attendant Services** (ARM 46.12.560) *Senior & Long Term Care* Barbara Smith 444-4064	Payment for trained dialysis attendants to assist dialyzing recipients at home.	-Provided only to recipients diagnosed by a physician as suffering from chronic end stage renal disease. -Provided only when there is no family member who can be trained to perform the dialysis. -Attendants must be licensed RN or LPN trained by home dialysis training center.	Department fee schedule	Exempt.
16. **Hospice** (ARM 46.12.1819) *Senior & Long Term Care Div* Barbara Smith 444-4064	Services and terms listed in Department rules.	-All services related to terminal condition to be provided by Hospice except for attending physician, personal care and HCBS waiver.	Federally set rates	Exempt.
17. **HOSPITAL** **In-Patient Hospital Services** (ARM 46.12.503) Jane Bernard 444-2528 Reimbursement and coverage *Quality Assurance Div.* Carol Jorgensen 444-4586 Utilization review	Medically necessary services ordinarily furnished in a hospital, including: -bed and board -nursing and other related services -use of hospital facilities -medical social services -drugs, biologicals, supplies, appliances and equipment -other diagnostic or therapeutic items or services -medical or surgical services provided by interns and residents-in-training	-Limited to medically necessary days, except drug/alcohol detox limited to four days unless condition requiring hospital care -Sterilization/abortions limited by federal requirements. -Acute Care Rehabilitation Units and Psychiatric Units. -Admissions subject to preadmission review by the department's designee or peer review organization. -Transplant services limited to Medicare approved facilities.	Prospective system based on diagnostic related groups (DRGs) for in-state and border hospitals. Cost based for free-standing psychiatric hospitals, distinct part rehabilitation units and out-of-state hospitals	$100.00 per discharge from the hospital.

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
Out-Patient Hospital Services (ARM 46.12.506) Jane Bernard 444-2528	Medically necessary preventive , diagnostic, therapeutic, rehabilitive and palliative services.	-Limited to emergency room services and services covered by Medicaid in non-hospital setting and ordered by or under the direction of a physician.	Prospective payment for ER, ambulatory surgery, dialysis, laboratory, imaging and other diagnostic services. Retrospective reimbursement for all other outpatient services, (Rural hospitals & MAFs are not subject to prospective payment.	$1.00 per line item.
19. **In-Patient Rehabilitation (Physical) Services** Jane Bernard 444-2528 Reimbursement & Coverage *Quality Assurance Division* Carol Jorgensen 444-4586 Joan Ashley 444-4121 *Senior & Long Term Care* Kelly Williams 444-4147 Skilled Nursing Facilities Utilization Review Prior Authorization: Mountain-Pacific Quality Health Foundation 443-4020 1-800-262-1545	Medically necessary services provided in the following settings: 1. Medicare certified hospitals; or 2. Medicare certified skilled nursing facility.	-Limited to acute care rehabilitation. -Limited to medically necessary days. -Rehabilitation centers which do not meet Medicare certification specified in "scope" are not covered. -Hospital admissions must be prior authorized by the Department's peer review organization. -Nursing home admissions must be prior authorized by the Department.	Cost-based.	Dependent of type of facility. See hospitals or nursing homes.
20. **Early, Periodic Screening Diagnosis & Treatment (EPSDT)** (ARM 46.12.514, 515, 516) Duane Preshinger 444-3182	Screening and diagnostic services to determine and treat physical and mental illness or handicap.	Limited to individuals under 21 years of age.	Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
21. **Medical supplies, prosthetic devices, and durable medical equipment** (ARM 46.12.801) Frank Malek 444-4068 Coverage & reimbursement *Quality Assurance Division* Carol Jorgensen 444-4586 PA for Air Fluidized Beds, Augmentative Communication Devices, Hospital Beds Purchase), Wheelchairs & Items costing $1,000 or more.)	Items listed in Department rules.	-Prior authorization as indicated in ARM. -Ordered by a physician.	Department fee schedule	$.50 per item.
22. **Mid-Level Practitioner Services** (ARM 46.12.2010) Randy Bowsher 444-3995	Limited to services provided within the scope of practice allowed by state law.	Services must be provided: 1. Within the level of physician supervision required by law; 2. Delivery of babies by nurse midwives must be in a licensed facility.	Department fee schedule.	$2.00 per service. (Pregnant women are Exempt.)
23. **Other laboratory and x-ray services** Randy Bowsher 444-3995	Laboratory and x-ray services performed in a physician's office or in a free-standing facility, including a hospital acting as an independent laboratory. Services may not be provided in a hospital outpatient department or clinic.	Laboratory and radiology services as ordered by a physician, dentist or optometrist.	Department fee schedule, or for laboratory services, 60 percent of the Medicare prevailing whichever is lower.	$2.00 per service in a physician's office.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
24. **Out-of-State Services** (ARM 46.12.502) *Quality Assurance Division* Joan Ashley 444-4121 Prior Authorization: Mountain Pacific Quality Health Foundation 443-4020 1-800-262-1545	All Medicaid Services which are not available in-state or within 100 miles of MT border subject to limitations specified in the next column.	-Out-of-state services are subject to the same limitations of the Montana Medicaid Program as in-state services. -May not go beyond 100 miles of the MT border for services, if the same services are available within that boundary. -Out-of-state services are allowed only when: .there is a medical emergency and the recipients's health would be endangered if he were required to travel to Montana to obtain the medical services; .the recipient travels to another state because the Department finds the required medical services are not available in Montana; or it is determined by the Department that it is general practice of recipients in a particular locality to use medical resources in another state; .the recipient or his representative can demonstrate to the satisfaction of the Department that out-of-state medical services and all related expenses will be less costly than in-state services; or .the recipient is a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments. .Inpatient services subject to preadmission review by the Department's peer review organization or designee.	Determined by type of service.	Amount is dependent on type of service provided. Refer to specific service for co-pay amount.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
25. **Outpatient drugs** (ARM 46.12.701) Dorothy Poulsen 444-2738 Betty DeVaney 444-3457 Manufacturers Rebate	Drugs approved by FDA and requiring a prescription and over-the-counter drugs which are insulin, asprin, laxatives and antacids.	-Prescribed by licensed practitioner. -Less-than -effective and experimental drugs are not covered. -Specific classes of drugs are limited to formulary products unless PA is obtained.	Maximum allowable cost (MAC) or estimated acquistion cost (EAC) plus dispensing fee.	$1.00 per prescription Generic. $2.00 per prescription brand name.
26. **Home Infusion Therapy** Rule # not yet assigned. Dorothy Poulsen 444-2738	Services listed in Dept. Rules, provided by licensed home infusion therapy providers.	Prescribed by licensed practitioner. Specific theapies as limited by Dept. Rule. May not be provided in a hospital.	Pharmacy - see outpatient drugs. Nursing - Home Health or PDN per Diem - Department fee schedule.	Pharmacy - Exempt Nursing - See Home Health or PDN Per diem $.50 per unit.
27. **Outpatient physical therapy, speech therapy and occupational therapy** (ARM 46.12.525A-46.12.527A) Michelle Gillespie 444-4066	Services listed in Department rules.	-Ordered by physician or mid-level practitioner -PT, ST & OT services limited to 70 hours per year without prior authorization by the Department. An additional 30 hours if determined medically necessary by the Department.	Department fee schedule.	$1.00 per hour.
28. **PASSPORT TO HEALTH** Amy Solich 444-4148	Recipients choose primary care provider who manages their care.	Limited to specific geographic areas of coverage, only certain services will be managed by primary care provider, refer to Department rules.	Department fee schedule.	Same as without PASSPORT.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
29. **Personal Assistant Services** (ARM 46.12.555) *Senior & Long Term Care* Barbara Smith 444-4064	In-home services, including assistance with basic personal care functions such as bathing, grooming, dressing, toileting, transferring, walking, meal preparation, feeding, help with self-administered medications, escort to obtain medical care. Some assistance with home management.	-Ordered by physician. -Supervised by licensed nurse at least 180 days. -May not be provided in a long-term care facility, including a licensed personal care facility. -Limited to 40 hours per week.	Department fee schedule.	Exempt.
Self-directed personal assistance services. (ARM 46.12.555) *Senior & Long Term Care Div.* Barbara Smith 444-4064	Client-directed personal assistance services.	-Ordered by a physician or health care professional.	Department fee schedule.	Exempt.
30. **Physician's Services** (ARM 46.12.12001) Randy Bowsher 444-3995 Fran O'Hara 444-3337 Claims Resolution	Services within the scope of the practice of medicine or osteopathy.	-Sterilizations/abortions limited by federal requirements. -Cosmetic services are not covered unless severe impairment to patient's physical and psycho-social well-being is demonstrated and treatment is prior authorized by the Department. -Treatment of infertility is not covered.	Department fee schedule.	$2.00 per service.
31. **Podiatry Services** (ARM 46.12.521) Randy Bowsher 444-3995	Services listed in Department rules.		Department fee schedule.	$2.00 per service.
32. **Presumptive Eligibility** (ARM 46.12.3401) Kathy Demme 444-4871	Ambulatory prenatal care for a time period of less than two months while formal application for public assistance is being made.	Ambulatory prenatal care (Approved Medicaid Services).	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
33. **Private Duty Nursing Non-hospital Services** (ARM 46.12.565) Duane Preshinger 444-3182 Reimbursement & coverage *Quality Assurance Division* Carol Jorgensen 444-4586 Utilization review.	Skilled nursing services outside of a hospital which includes RN and LPN services.	-Ordered by a physician. -Prior authorized by Department. -Recipients must be under 21 years of age or receiving as part of home infusion therapy. -Respite care is not covered.	Department fee schedule.	Exempt, except for home infusion therapy
35. **QDWI (Qualified Disabled & Working Individual)** Kathy Demme 444-4871	Medicaid pays Medicare Part A premiums.			
36. **QMB (Qualified Medicare Beneficiary** Kathy Demme 444-4871	Medicaid pays Medicare premium, co-insurance and deductibles.		Up to Medicaid allowable charge or rate.	Established by service item.
37. **Respiratory Therapy Services** Michelle Gillespie 444-4066	Treatment in the home by a Licensed Respiratory Care Practitioner.	-Ordered by a physician. -Limited to individuals under 21 years of age/	Department fee schedule	Exempt.
38. **School Based Services** Michelle Gillespie 444-4066	Medical care provided for children in a school setting.	Limited to individuals under age 21.	Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
39. **Skilled and intermediate nursing services in long term care facilities.** *Senior & Long Term Care* Steve Blazina 444-4129	Meal services, medications, nursing and other health services, rehabilitative services, social services and activities programs.	-Ordered by a physician. -Certified by Department for level of care prior to admission/payment.	-Prospective per diem rate, composed of operating, direct nursing and property rates. -Prescription drugs & rehabilitation services (OT, PT, ST) are reimbursed on a fee schedule basis. Other ancillaries are reimbursed at provider acquisition cost.	Exempt.
40. **Out of State Nursing Homes** (ARM 46.12.1251) *Senior & Long Term Care* Kelly Williams 444-4147	Same as above.	Physician ordered prior approval by Department level of care certified.	Rate established by the State Medicaid agency in the state where facility is located.	Exempt.
41. **Swing Beds** *Senior & Long Term Care* Kelly Williams 444-4147	LTC Services provided in swing beds when no NF beds are avail-able in community & resident meets level of care.	No NF beds available in 25 mile radius of discharging hospital. Must be NF level of care.	Prior calendar year statewide average Medicaid rate for nursing facilities. (NF)	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
42. **Targeted Case Management** (ARM 46.12.1901-1940) Shari Pettit (HPSD) 444-2574 Pregnant Women Special Health Needs *Disability Determination Division* James Driggers 444-4090 Developmentally Delayed *Addictive & Mental Disorders Div.* Randy Poulsen 444-2706 Adults with Chronic Mental Illness, Severely Emotionally Disturbed Children.	Services designed to assist individuals in accessing needed medical, social, educational and vocational services. The four target groups covered are: -Pregnant women and infants through 1 year of life. -Individuals 16 years of age and older with developmental delays. -Individuals 18 years of age and older with severe mental illness. -Individuals up to 18 years of age with severe emotional disturbance.		Department fee schedule.	Exempt.
44. **Transportation and per diem/Ambulance** (ARM 46.12.1001-1025) Kathy Demme 444-4871 Reimbursement & Coverage Prior Authorization: Mountain-Pacific Quality Health Foundation 1-800-292-7114	Ambulance services, air transport, specialized non-emergency transportation services, commercial transportation, mileage and per diem.	-All non-emergency transportation must be prior authorized by MWFMC. -Ambulance must be licensed under state law. -Ambulances are covered for emergency care and for non-emergency care when the patient is stretcher-bound and the ambulance I s ordered by a physician. -Transportation is only covered to obtain medically necessary services from nearest provider. -Transportation is limited to the least expensive means suitable to meet the recipient's needs.	Department fee schedule.	$1.00 per trip Specialized non-emergency.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
45. **Indian Health Services** (Sec. 1905B, 1911A of the Social Security Act.) Debra Stipcich 444-4834	Services provided by Indian Health Service Facilities.	Outpatient and Inpatient Services.	Fees set by HCFA annually per visit for outpatient per diem for inpatient.	Exempt.
46. **Health Insurance Premium Payment** *Quality Assurance Div. - TPL* 1-800-457-1978	Group and Individual Health Policies	Health Plan must be determined to be cost effective by TPL prior to reimbursement.	Determined by TPL.	
47. **Medicare Buy-In** *Quality Assurance Div - TPL* Lynn Roberts 444-4552	Payment of Medicare premiums for QMB, SLMB, QDWI and SSI recipients.	Must be eligible for QMB, SLMB, QDWI or SSI related program.	Based on current year's Medicare premium rate as set by SSA.	
48. **Home and Community Based Services for Persons with Developmental Disabilities (DD Waiver).** (ARM 46.8.2005) *Disability Services Division* James Driggers 444-2995	Home and Community-based services designed to serve individuals in the community who would otherwise require services from an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR). Services include Family Education and Support Services, Supported Living and other residential options, as well as Day/Work Services.	Recipients must meet ICF/MR level of care and be eligible for DD Services. Average cost of care in the community cannot exceed cost of ICF/MR care.	Reimbursement varies by service.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SRS-MA/FA-456
(Rev. 11/91)

STATE OF MONTANA
Department of Social and Rehabilitation Services

PROVIDER INQUIRY OF MEDICAID/STATE MEDICAL ELIGIBILITY

Instructions: Please complete the provider section of this form, sign and date, attach the applicable Statement of Remittance, and send to the client's welfare office. If you do not receive a response within ten days refer to your Medicaid Management Information System Provider Manual, Recipient Eligibility Section, for the county contact person. If you need more provider inquiry forms, please contact Consultec for reordering.

Provider: ______	Provider ID Number: ______
Address: ______	Provider Phone Number: ______
City: ______	Date of Inquiry: ______
Patient:	**Parent or Guardian:** (if patient is a minor)
Name: ______	Name: ______
ID # ______	ID #: ______
Date of Birth: ______	Address: ______
Date of Service: ______	City: ______

Information Being Requested:

Please attach a copy of the Statement of Remittance. Highlight the line in question.

Signature of Requestor	Date
______	______

County Response:

Dates of Eligibility: ______

Signature of County Respondent	Title	Date
______	______	______

Distribution: Initial Request
Provider - Pink
County Office - Canary & White

County Response
County - Canary
Provider - White

RELEASE OF CONFIDENTIAL INFORMATION

Consumer's Name: ____

SSN: ________________________

Address:

____

____

I, ____ authorize the release of:

__________ medical information

__________ social information

__________ financial information

to: ____

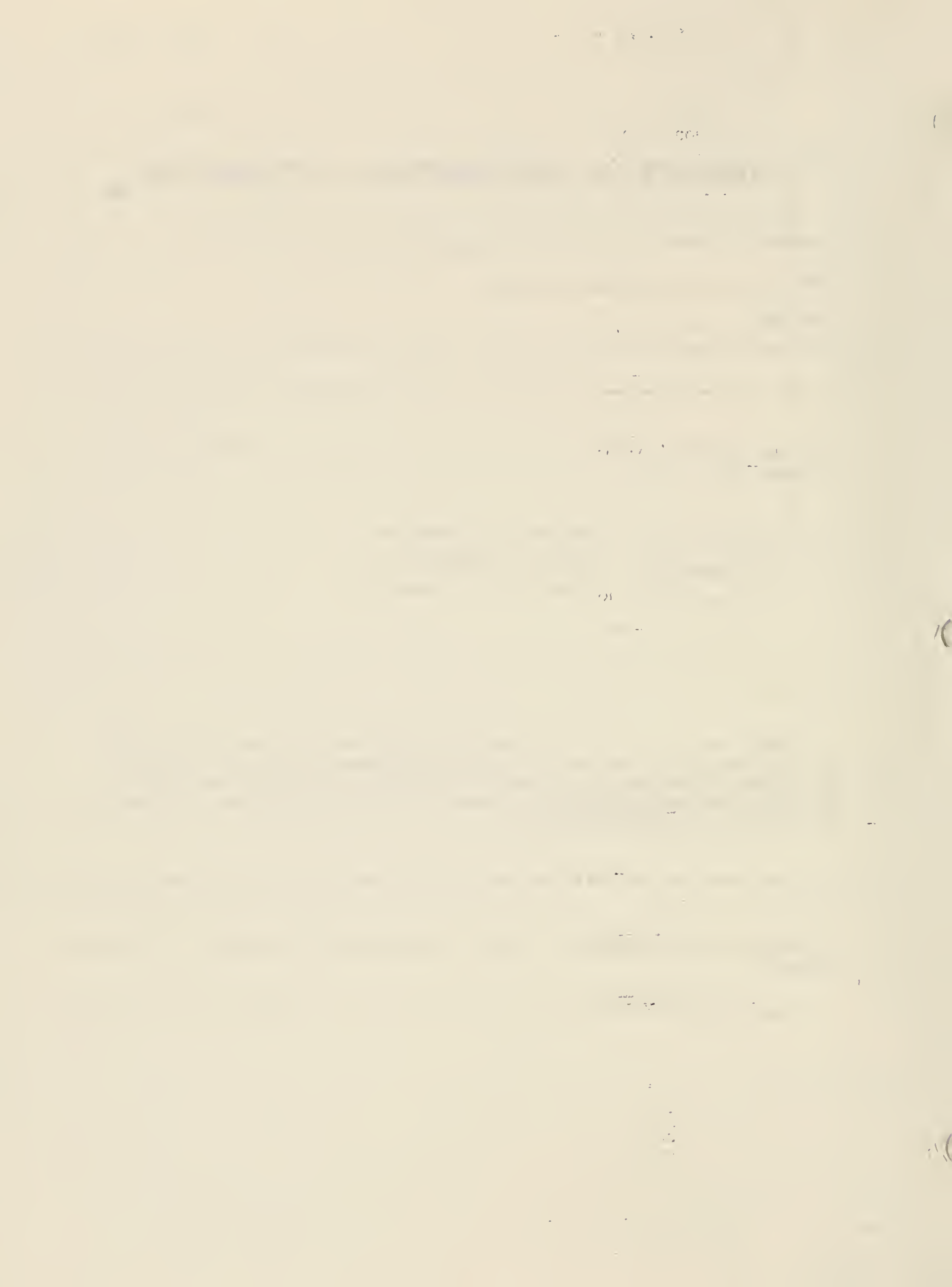
____

I understand that any information obtained will be kept confidential and will be used only for purposes directly connected with the formation of a Plan of Care and only for the time period I am requesting enrollment in the Self-Directed Personal Assistance Services program.

****

Signature of consumer or legal representative signing in his/her behalf:

____ Date: ____________



Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
07/01/03

Please make the following revisions to your Self-Directed Personal Assistance Services Manual. Pages referred to under description of change are the old manual pages.

SECTION	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Updated revision dates for below sections.
606	Reimbursement Methodology	Changed procedure code Z0564 and Z0569 to T1019 U9, added "Modifier" under procedure code Z0564 on page 2.
802	Community Services Bureau Central Office Staff	Changed Barbara Smith to Denise King
803	Regional Program Officers	Updated directory.
804	Personal Assistance Providers	Updated directory.
805	Self-directed Personal Assistance Providers	Updated directory.
908	Self-Directed Personal Assistance Services Utilization Report	Change Z0566 & Z0567 to T1019 on page 2 & 3. Change Z0564 and Z0569 to T1019 U9 on page 3 table 2.

Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
4/01/04

Please make the following revisions to your Self-Directed Personal Assistance Services Manual. Pages referred to under description of change are the old manual pages.

SECTION	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Changed date to "04/01/2004" on Sections 001, 103, 204, 308, 310, 401, 403, 404, 408, 410, 411, 412, 413, 414, 415, 417, 419, 502, 503, 504, 505, 604, 605, 606, 608, 701, 702, 703, 705, 707, 708, 713, 802, 804, 805, 807, 901, 902, & 903
103	Definitions	Pg 1 Under Case Management added "HCBS"; added "CMS" definition; Under Fiscal Intermediary added "In Montana, this is ...."; Pg 2 under Health Maintenance Activities added "skilled that are exempt from the Nurse Practice Act"; under Home & Community Based Services changed the definition; added IADLs definition; added Medically Necessary Service definition; Pg 3 under Prior Authorization reworded definition
204	Organizational Responsibilities	Pg 2 under Mountain Pacific Quality Health Foundation, changed "peer review" to "Quality improvement (QIO)"
308	Quality Improvement Process	Changed in header "Assurance" to "Improvement"; Pg 1 #4 Changed "Personal" to "Consumer"; PG 2 #5 added "(Reference SDPAS 417)";
310	Principles of Charting	Pg 1 Change "Mechanics of Charting" to "Charting Requirements"; added "This section addresses the minimal charting requirements"; under #2 deleted "writing the word error above it"; Pg 2 #2 deleted examples and added Objective and Subjective;
401	Medicaid Eligibility Requirements	Pg 1 inserted table with contact information; Pg 2 added "it is the provider's responsibility for verifying the identity and eligibility of............"; Pg 2 under FAIM added "coverage"; Rearranged order of eligible programs listed.
403	General Provisions & Requirements	Pg 1 Paragraph 3 added "and is deemed medically necessary"; Pg 2 added "3. Conservator"; renumbered list; Last Paragraph added "criteria:"; Pg 3 deleted #4; Paragraph 1 deleted "who is already in the authorization system"; #1 added "Activities of Daily Living (ADL)" & "examples of meal preparation activities include........."; Pg 4 deleted #3 & renumbered; #4 added "Instrumental Activities of Daily Living (IADL)"; Paragraph 4 under #4 added "Household tasks may not be authorized for the purpose of supervising the consumer"; Pg 4 Paragraph 3 added "(Reference SDPAS 707)"

Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
4/01/04

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SECTION	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Changed date to "04/01/2004" on Sections 001, 103, 204, 308, 310, 401, 403, 404, 408, 410, 411, 412, 413, 414, 415, 417, 419, 502, 503, 504, 505, 604, 605, 606, 608, 701, 702, 703, 705, 707, 708, 713, 802, 804, 805, 807, 901, 902, & 903
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Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
4/01/04

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SECTION	SUBJECT	DESCRIPTION OF CHANGE
404	Service Limitations and Exclusions	Pg 1 #2 Added "when the family is unable or unavailable"; #3 changed "may shop" to "may not shop"; #4 added "Household tasks may not be authorized for the purpose of supervising the consumer"; Pg 2 added #7; Services to Children Paragraph 1 added "when the parent is unqualified or otherwise unable to provide the personal assistance" & added "712"
408	Freedom of Choice	Paragraph 2 added "Reference SDPAS 803"; deleted Paragraph 3.
410	High Risk Referrals	Page 1 Paragraph 2 added "The provider must complete the Temporary Authorization and the Overview/Referral and fax it to the foundation"; added paragraph #3; paragraph 4 added "/personal representative";
411	New Admissions (Initial)	Pg 1 #1A deleted "Significant Other"; #1B2ii added "transmits the referral (DPHHS-SLTC-154)"; Pg 2 #4 changed "20" to "10"; Pg 2 deleted "A, B, C, & D"; Pg 2 #5 added "MPQHF"; #6 added "Profile and Capacity Addendum"; Deleted #8; Pg 3 added "A, B, C & D"; Added Flow Chart
412	Request to Change Agencies	#4 added "and profile"; #5 added "and get a copy of the signed Health Care Professional Authorization........"
413	Switch in Options	Pg 1 #2 added "Change"; renumbered page 1; #5 added "The new agency is entered into the database"; #6 changed "a denial notice is sent out" to "referral is made to the RPO for follow-up........"; Added second paragraph under #6. Added Flow Chart
414	High Risk Cases	Pg 1 #4 reworded paragraph; #5 added "personal representative"; #6 deleted last sentence and added "The consumer has 30 days to select a personal..............."; #7 added "prescreen and/or overview and profile"
415	Annual Reviews	Pg 1 paragraph 1 deleted "and"; #1B added "makes appropriate corrections and/or additions........"; Pg 2 added #E.
417	Request to Amend Authorizations	Pg 1 #1A added "post hospitalization requests should be sent upon........"; #1B added "and no more than 3 hours per week"; #1C added "and is medically necessary"; #2 added "medical/functional condition and must include...."; Pg 2 #2C1 added "the Agency is authorized to continue with the temporary authorization until......"; #2C2 rewrote paragraph; Deleted #2C3

Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
4/01/04

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SECTION	SUBJECT	DESCRIPTION OF CHANGE
419	Change in Personal Representative	Pg 1 Paragraph 2 deleted "agency" & added "and identifying the new personal representative"; Pg 1 paragraph 1 deleted 2nd sentence and added "the provider need to notify the RPO who will facilitate transfer…."
502	New Admissions	Pg 1 paragraph 2 Changed "20" to "10"; Changed last sentence in Paragraph 2 to "the Foundation may Prescreen within 10 working days via a telephone……."; added #4 "when necessary, distribution of the agency selection guide"; Pg 2 Paragraph 3 changed "onsite visit" to "a capacity addendum"; paragraph 1 deleted "if the consumer has gone through the authorization process"; paragraph 7 changed "necessary" to "if HMA tasks are being added"; Paragraph 1 deleted last sentence;
503	Personal Assistance Services Consumer Overview/Referral (DPHHS-SLTC-154)	Pg 1 revised paragraph 1; revised paragraph 2; paragraph 5 added "applicable boxes"; paragraph 6 added "readmit"; Pg 3 changed "personal care needs" to "reason for referral"; paragraph 3 added "or other primary provider"; Paragraph 7 deleted "this section to be completed by PAS agency only"; Pg 4 deleted "Page 2 For foundation Use only"; changed "describe consumer's overall health" to "Summary of consumer's health and reasons for authorization of care"; Pg 5 deleted "page 4 for Foundation use only"; Last paragraph changed "their" to "personal"
504	Personal Assistance Services Profile (DPHHS-SLTC-155)	Pg 1 under Purpose added "ADL"; "IDL"; "HMA"; Instructions deleted "if short term, set date span"; Pg 2 Effective date added "if the profile is an approved amendment…."; deleted "Consumer's Medicaid Number"; Pg 3 last paragraph changed "capacity" to "independence"; changed "capacity" to "ability"; Pg 7 #14t deleted "may also need assistance with colostomy care"; #15 revised both columns; #16 added "intermittent"; Pg 9 revised paragraph 2 under Meal preparation; revised Date Provider Selected section on Page 11
505	Self-Directed Personal Assistance Services Authorization (DPHHS-SLTC-152)	4th paragraph under Instructions changed "HT" to "IADL"
604	Payment Requirements	Pg 1 added on #4 "and services are delivered within an…."

Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
4/01/04

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SECTION	SUBJECT	DESCRIPTION OF CHANGE
605	Payment Processing	Paragraph 1 changed "HCFA-1500" to "CMS1500"
606	Reimbursement Methodology	Updated Modifier Information
608	Records Retention	#9 Changed "HCFA-1500" to "CMS-1500"
701	Consumer Capacity	Paragraph 1 added "personal representative"; Paragraph 2 added "and the PR is screened for capacity using the addendum"
702	Program Oversight	Pg 1 #1 added "parameters"; #2 added "personal representative"; #3 revised; #4 revised; #5 revised;
703	Recertification	Pg 1 #1 Deleted "and Update as needed"; #5 added "based on medical necessity/functional impairment is identified" & "Include the Temporary Authorization ...."; Pg 2 revised paragraph 1 under Annual Review.
705	Termination of Services/ Discharges/Temporary Absences	Pg 1 paragraph 2 added "(Reference ARM 37.40.1102). The following is not........."
707	Mileage and Escort	Pg 1 Paragraph 4 added "Documentation of mileage includes client, attendant, odometer readings........."
708	Reporting of Serious Occurrences	Pg 1 paragraph 1 added "or an agency specific form"
713	Services to the Developmentally Disabled	Added "State Plan will not reimburse.........."; added "No duplication of payment or services is allowed"
802	Community Services Bureau Central Office Staff	Changed "Joyce DeCunzo" to "Vacant"; added "Home Dialysis" under Denise King; added "Robin Homan" with Cecilia Cowie.

Self-Directed Personal Assistance Services
Revisions Transmittal, No. 8
4/01/04

Please make the following revisions to your Self-Directed Personal Assistance Services Manual. Pages referred to under description of change are the old manual pages.

SECTION	SUBJECT	DESCRIPTION OF CHANGE
804	Personal Assistance Providers	Pg 1 Column 1 row 2 changed contact person; Column 2 row 2 changed phone and fax numbers; Column 2 row 5 changed fax number; Column 1 row 6 changed address; Pg 2 Column 1 Row 2 added address; Column 2 row 5 changed phone number; Pg 3 Column 3 row 4 changed counties; Column 2 row 5 changed fax number; Column 1 row 6 changed address; Column 2 row 7 changed phone and fax number; Pg 4 Column 1 row 6 changed contact person; Column 1 row 8 changed contact person; Column 3 row 8 changed counties; Pg 5 Column 1 row 2 changed contact person; Column 2 row 6 changed fax number; Column 2 row 8 changed fax number
805	Self-Directed Personal Assistance Providers	Pg 1 Column 1 Row 2 changed contact person; Column 2 Row 2 Changed phone and fax numbers; Pg 2 Column 1 Row 3 Changed address; Column 1 Row 8 Changed address; Column 2 Row 7 Changed fax number; Pg 3 Column 2 Row 2 changed fax number; Column 3 row 2 changed counties; Column 1 row 5 Changed contact person; Column 1 row 6 changed contact person; Column 3 row 6 changed counties; Pg 4 Column 1 row 2 changed contact person; Column 1 row 4 changed address and added contact person; Column 2 row 4 added phone number
807	Mountain Pacific Quality Health Foundation Staff	Made changes to names and phone numbers, added map.
902	General Utilization	Row 2 Column 2 Changed "Consumer Overview" to "Service Plan"; Row 7 Column 2 changed "Amendment request form" to "Overview/Referral" , deleted "same as intake"; PG 2 Row 3 Column 3 added "SDPAS Agency"
901	Self-Directed Personal Assistance Services Forms Requisition	Updated the Revision dates on 158, 160, 164, 165, 166.
903	Self-Directed Personal Assistance Services Temporary Authorization (DPHHS-SLTC-160)	Pg 1 paragraph 1 added "or a temporary increase in hours that will exceed 14 days"; Divided Paragraph 2 into 2 separate paragraphs based on "High Risk" and "Change in Profile" reworded both paragraphs; Under Distribution: changed "within three working days of receiving the referral" to "on the day the temporary is implemented"; deleted "Note ….."